REPORT RESUMES

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A MAJOR EFFORT WAS MOUNTED TO INCREASE, EXTEND, AND IMPROVE HEALTH SERVICES FOR MIGRANT AGRICULTURAL WORKERS IN NEW JERSEY DURING THE SECOND YEAR OF OPERATION, 1964. THE MIGRANT HEALTH PROGRAM PROVIDED--(1) SERVICE TO 453 CAMPS, (2) OPPORTUNITY FOR 5,000 PERSONS TO COMMUNICATE WITH THE NURSE OR OTHER HEALTH WORKER WHO VISITED THE CAMP, AND (3) DIRECT VISITS TO OVER 1,300 PERSONS FOR MANY REASONS, PRINCIPALLY TUBERCULIN SCREENING AND HEALTH COUNSELING. TRIALS OF SERVICES BEYOND BASIC SCREENING AND IMMUNIZATION PROGRAMS WERE CONDUCTED IN NUTRITION, DENTISTRY, AND HEALTH EDUCATION. HOSPITAL PARTICIPATION IN MIGRANT HEALTH ACTIVITY WAS EXPANDED. HOWEVER, A DEFICIT IN FUNDS FOR IN-PATIENT CARE WAS A PROBLEM. PROGRESS WAS NOTED IN THE DEVELOPMENT OF EFFECTIVE COMMUNICATION CHANNELS BETWEEN THE MIGRANT IN NEED AND THE PROFESSIONAL WORKER. REPORTS OF THE 1964 EFFORT ARE PRESENTED UNDER THE FOLLOWING HEADINGS--LOCAL MEDICAL LEADERSHIP, EMERGENCY MEDICAL CARE, MATERNITY SERVICES, DENTAL SERVICES, MIGRANT CLINICS, MIGRANT SCHOOL HEALTH SERVICES, CAMP VISITATIONS, MEDICAL SOCIAL SERVICES, HEALTH EDUCATION, SANITATION AND ACCIDENT PREVENTION. APPENDICES PRESENT STATISTICS, WORKSHOP AND CONFERENCE NOTES, AND CASE STUDIES. (SF)

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MIGRANT HEALTH PROGRAM

NEW JERSEY 1964

NEW JERSEY STATE DEPARTMENT OF HEALTH

ALFRED M. POTTS, 2d

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TABLE OF CONTENTS

Pages

A Nation of Migrants -- 1 - 4
Local Medical Leadership ------------------------------------ 5
Emergency Medical Care -------------------------------------- 6 - 7
Maternity Services -- 8
Dental Services --- 9 - 10
Migrant Clinics --- 11 - 13
Migrant School Health Services ------------------------------ 14 - 16
Public Health Nursing Summary ------------------------------- 17 - 20
Reports of Individual Service ------------------------------- 21 - 27
Specific Problem Cases -------------------------------------- 28 - 30
Camp Visitations -- 31 - 33
Medical Social Services ------------------------------------- 34 - 44
Health Education -- 45 - 48
Sanitation and Accident Prevention -------------------------- 49 - 51
Evaluation -- 52 - 54
Recommendations --- 55 - 57
Appendix I - Migrant Clinics -------------------------------- 58 - 60
Appendix II - Individual Service ---------------------------- 61 - 69
Appendix III - Problem Cases -------------------------------- 70 - 74
Appendix IV - Camp Visitation ------------------------------- 75 - 82
Appendix V - Social Service --------------------------------- 83 - 134
Appendix VI - Health Education ------------------------------ 135 - 182
Appendix VII - Accident Prevention -------------------------- 183

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MIGRANT HEALTH PROGRAM
NEW JERSEY 1964

William J. Dougherty, M.D., M.P.H.
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> "The homeless, rootless migrant comes into community after community in which it is made clear to him that he is considered a necessary evil, that what is desired of him is that he do his job but not participate in community activities and when the job is done to be on his way as rapidly as possible. We as professionals and citizens have a role, both in terms of legislative effort and of direct relationships."

A NATION OF MIGRANTS

The history of the United States is based upon migration. People moved westward from Europe to a new continent. Their desires and curiosity drove them westward to the Pacific. Today we are witnessing a south-to-north, off-shore-to-mainland migration of people who by and large are seeking a better way of life for their families, or are curious explorers of an area in which they may choose to settle.

The continuing migration of Southern Negroes to the Northeast and Midwestern states provides them with increasing opportunities for experience, understanding and employment. The migrations of citizens of the Commonwealth of Puerto Rico will spread across the United States as surely as previous migrations spread from Maine to California. This long delayed interchange will modify the cultural patterns of the United States and produce a growing solidarity between the mainland and Puerto Rico.

The social and health needs of migrants are many, and the means to meet them are scarce. Many areas affected by migration have little or no health service for their year-round residents and less for seasonal migrants. Those areas with services and facilities often find that they are overtaxed by seasonal workers. The current program in New Jersey serves to demonstrate the need for providing and developing such services. In ten years all New Jersey agricultural counties should have well-developed, effective health services for year-round residents with a flexible potential to serve the seasonal migrants who with the expansion of automation to agriculture, will be needed in smaller numbers to harvest the state's abundant crops.

Under the leadership of the New Jersey State Department of Health, and with a continuation of federal funds for the project, migrant health activity in 1964 was expanded to include a new breadth and intensity of services. New Jersey, long a pioneer in the field, succeeded in reaching a stage of development never before achieved. Observations evolving from this program are expected to benefit every farm community in the state, and hopefully, to be of benefit to other migrant programs that have been making progress over the years throughout the United States.

Final figures for the number of migrant workers at the peak crop season are not yet available. The 1963 peak was reported at 24,250. The Migrant Labor Bureau and the Farm Placement Bureau estimate the 1964 season peak at 25,000, with 21,871 workers housed in the state. Although about 8,000 Southern migrants were expected in 1964, actual arrivals as reported by the Farm Placement Bureau were only 7,463. Florida crew leaders had overestimated the number of workers they could recruit for New Jersey employers. No figures are available for expected number of non-organized workers.

The two contract labor associations supplying migrants have reported on the number of workers recruited. Glassboro Service Association records 8,389 contract Puerto Rican males, 1,500 Puerto Rican and Negro walk-ins, and 705 foreign nationals. The Farmers and Gardeners Association reports 927 contract Puerto Rican males, 325 Puerto Rican and other walk-ins, and 65 foreign nationals from the British West Indies. The remaining 5,000 workers would consist of Puerto Rican walk-ins from Puerto Rico and from the Southern states, Negro walk-ins from the South, and day-haul workers from adjacent metropolitan areas.

The Farm Placement Bureau estimates the children of crews to number 513 under the age of 16, while the Migrant Labor Bureau lists nearly 2,000 children under 16 housed in camps in 1963 and estimates that half of the 1,500 women were nonworking.

Migrants began to arrive between April 1 and April 15, and most had left by November 1. The Farm Placement Bureau lists principal places of origin as Puerto Rico, Florida, Virginia, Georgia and North and South Carolina. A distribution of a sample is given in the Field Nursing section of this report.

The number of camps by county is reported by the Migrant Labor Bureau, but 1964 figures are not yet available. The 1963 statistical report gives figures which may not be materially different. A map showing camp distribution and major concentrations is available from the Bureau for the year 1961. Information regarding camp visits is included in the statistical data accompanying this report. Changes in agriculture, labor and economic conditions are covered in detail in the Farm Placement Bureau's Annual Farm Labor Report, which is expected to be available by February.

An early start in planning, based on experience of previous years, brought New Jersey's 1964 Migrant Health Program to a state of readiness for the first arrivals of the season. In the early spring the Department opened an office in Woodstown, New Jersey to provide a headquarters for field personnel who were assigned in Salem and Gloucester counties. This office has become a reference point to which farmers, migrants, physicians and hospital personnel are now turning with increasing frequency for service.

This is the first season in which services were immediately available in the early spring. Nursing agencies under contract with the Department were also authorized and urged to provide services to migrants at the beginning of the season. For the first time, a public health nurse was assigned by the Department of Health in Salem and Gloucester counties in April, to provide service to families at a time when the early spring crop of asparagus was being harvested.

On June 29 an extensive orientation conference was held for all field personnel, at State Health Department headquarters. The person responsible for each phase of the program described in detail plans for the season's work. In the past, most orientation programs had centered on public health nursing activities. The breadth and depth of services included in the expanded migrant program were demonstrated by the presence of social workers, educators, sanitarians, dental health representatives, accident prevention experts, together with nurses, both as program participants and as part of the audience.

Other innovations included a comprehensive orientation made available for the dental students in advance of the school program which prepared them for more effective performance. Emphasis was placed on alerting farmers, migrants and community officials to the fact that the program would assist in handling dental emergencies. Dental students from the University of Pennsylvania and Temple, George Washington and St. Louis Universities obtained a practical field orientation in Dental Public Health by serving in the school program and in adult clinics.

Another unique aspect of this year's activities was a contract negotiated by the Department in May with the National Travelers Aid. NTA assumed responsibility for providing social services to migrant workers in Cumberland, Gloucester and Salem counties. This service grew vigorously throughout the spring and summer, and remained active in the fall and winter providing services to those migrants who attempted to stay over to settle, or who were deserted in New Jersey.

Still another "first" was the amplification of the social service program by a joint agreement with the Commonwealth of Puerto Rico, which made possible the recruitment and assignment of a Puerto Rican social worker. This addition made the program of service bilingual and bicultural. A gradual insight into cultural patterns of behavior under stress of illness is now being obtained.

A major endeavor in health education was launched when the Department recruited an experienced health educator. Almost simultaneously a health educator was assigned from Puerto Rico under a joint agreement. Field staff was amplified by college students whose interest and enthusiasm made valuable contributions to the work of attitude surveys, group discussion sessions and special programs of health instruction.

The assignment of two professional personnel from Puerto Rico with capacity to relate to the migrant worker served a previously unrecognized need in relationship to the courts. Here, when the Spanish-speaking migrant worker became involved in a legal problem, the courts and the worker had the benefit of perceptive, professional bilingual interpretation. Such experience also gave the Puerto Rican professionals who planned to return to the Island an insight into the relationship between behavior and law on the mainland. In addition, as a result of the social service staff's involvement in health, social and legal problems of migrant workers, the Bar Association of one county made plans to provide legal aid to migrant workers.

The introduction of the Rapid Plasma Reagin screening test for syphilis into field clinics made possible the immediate referral of reactive patients to treatment clinics or to private physicians.

The establishment of a prenatal clinic in Gloucester County provided a service that had been lacking in previous seasons. It made this form of care more readily available, and since it included referral of the migrant to physicians' offices, it began to break the barrier that exists between migrant and community. In this environment, the migrant patient received the same service in the same atmosphere as any member of the community.

Salem County Memorial Hospital established for the first time regularly scheduled out-patient medical and surgical clinics, which made available to migrants as well as the general community a new source of medical care for low-income people. Another first was Salem County's establishment of the new office of County Health Coordinator, by action of the County Board of Freeholders. This is an essential step towards development of local responsibility and county participation in providing health services for the whole community, including the sizable migrant population. It is to be hoped that in the future this body will evolve a unified program for migrants as a move towards the assumption of total responsibility for this area by the local government.

For the first time, the sanitation program undertook a water-sampling activity. As a result, previously unrecognized health hazards were brought to the attention of owners and operators. Some of the water supplies found to be contaminated were repaired, sterilized and re-tested to assure their potability. An outcome of this demonstration will be increased attention to water supplies in other areas of the state.

In the everyday activity of community agency staffs there has been a growing preception of health needs of migrants, a well-defined path to solution of difficulties, and an increasing ability to render services. This change was observed most keenly in the hospitals of the state where the migrant with a problem is being identified earlier, is referred for assistance sooner, and is thus provided with a better chance to receive planned care upon return to the migrant camp or community.

More attention was paid to the overall needs of families, not only health needs but also their social, economic and legal needs. Areas of service that were studied in greater depth included hospital and clinic services, physician services, and problems associated with general assistance and surplus food distribution.

LOCAL MEDICAL LEADERSHIP

> "The physician was overheard to say to a woman, 'You've done a good job, Mother.' I am sure this kind of simple but personal commendation must have meant a good deal."

Participation of local physicians for the second year continued to deepen the program's vital community roots. Existing contracts with medical practitioners were renewed and clarified, and new contracts made with additional physicians to supply consultation, clinic services and emergency office care for the expanded migrant program, particularly in areas where hospitals were geographically inaccessible.

Physician contracts varied from county to county, with some communities more developed than others in the readiness to assume medical leadership. In general physicians were recruited to serve remote areas, to diagnose and treat patients and refer them to hospitals as needed, and to give medical assistance and direction to screening programs at the local level. It was observed that migrants were better served this year not only in health but also in social and welfare needs because participating local physicians helped promote community acceptance of the migrants.

Physicians under contract to treat migrants in their offices at $5.00 per visit, reported 24 visits for a total of $120. In addition, nine other private physicians, mainly in Cumberland County, reported a total of 24 patient visits, costing $118. Local practitioners in three counties devoted a total of 41½ hours of professional service in the supervision and operation of migrant health clinics. Although in most instances the value of their service was far in excess of the agreed rate of $10.00 per hour, total cost to the program was limited to $415.

Medical leadership was particularly evident in Salem and Gloucester Counties, where the local medical director succeeded in enlarging community interest and support and brought a vigorous teamwork approach to the organization of field operations because of his personal knowledge of and contacts with farmers, hospitals and other physicians in the area.

In nearly all cases, the nominal fee arranged by contract for payment of services was of relatively minor importance to the physicians involved. They considered their services as a community contribution and a professional responsibility.

EMERGENCY MEDICAL CARE

> "One of the largest problems in the whole operation of migrant health programs throughout the country is the provision of hospital service."

The agreement arrived at in 1962 and continued through 1963 between the New Jersey State Department of Health and the New Jersey Hospital Association and its member hospitals yielded a wealth of statistical data as the basis for future planning for expanded emergency hospital care services for migrant workers to be financed, in cases of indigency, through official or voluntary funds. Perhaps the most crucial figure was the $33,000 of 1963 in-patient charges, against which only $9,000 was available to apply for payment to the hospitals.

The unpaid portion of these bills fell heavily on the hospitals. The Migrant Labor Board in March 1964 unanimously recommended that the State of New Jersey provide additional funds to pay for a part of the hospital bills to be incurred by indigent migrants in 1964 and in 1965, and that a supplemental appropriation also be granted to the Department of Institutions and Agencies for the same purpose.

Since direct financial assistance from the State for more complete payment of these anticipated charges was not forthcoming, means were sought to draw on appropriated funds which were available for use on a shared payment basis through municipal welfare departments. Until techniques to use such means are developed, the $9,000 of State funds earmarked for emergency medical care remains the only possible source for in-patient hospital care payment for general conditions.

This is a particularly crucial situation because hospitalization needs for migrant workers during 1964 were greatly in excess of those needs in the past as a result of increased medical services being provided by the State Department of Health and the consequent improvement in case finding. At the same time, rising hospital costs increased the deficit still further.

For services rendered between July 1 and December 15, 1964, in-patient bills totaling $47,950.90 were submitted by 16 hospitals. Of this total, $42,813.58 was verified and will be considered for reimbursement with the $9,000.00 appropriated by the New Jersey State Legislature. These bills covered admissions of 113 patients. It should be noted that between January 1 and June 30, 1964, migrants arriving early in the season incurred expenses in 11 hospitals, for which bills were submitted in the amount of $10,917.04. Although $9,649.79 of these bills was verified, no funds from fiscal 1964 remained and no payment could be made.

The 113 hospital admissions of migrants reported for the period July 1 through December 15 accounted for 1,675 days of in-patient care. Adding 46 admissions reported between January 1, 1964 and June 30, 1964, 400 more days of in-patient care were counted. Combining the figures for the two periods of calendar year 1964, 159 admissions, representing 2,075 days of patient care were counted. The average length of hospital stay derived from these figures is slightly over 13 days per admission. Costs billed to the program for in-patient service averaged a little over $22.50 per day. Over 90 different diagnostic categories were reported.

An agreement for reimbursement of out-patient hospital services was reached between the State Department of Health and New Jersey Hospital Association whereby member hospitals wishing to provide out-patient clinic, emergency room, laboratory and X-ray services for migrants might be reimbursed their full costs according to scheduled charges up to a limit of the available funds, which were $2,500 for the year.

Out-patient, services for 249 patients during the period July 1 through December 15, 1964 by 12 hospitals and submitted for payment to the Migrant Program totaled $2,700.52. Of these, bills for $2,414.57 were verified, and will be considered for payment in full. The verified total was divided between X-ray and laboratory services ($1,346.50) and clinic and emergency room charges ($1,068.07). Out-patient service in the period January 1 - June 30 amounted to $494.75. Of this amount, $428.60 was accrued by verified migrants. This sum is divided between lab and X-ray ($36.50) and out-patient and emergency room service ($392.10). Consolidating the two verified amounts for January 1 to December 15 gives a total of $2,843.17. However, only the charges incurred after July 1 can be considered, since no funds remain from the previous fiscal year to meet the needs of the January-June period.

MATERNITY SERVICES

> "A baby's formula is sent home from the hospital with the infant, and everyone assumes that the parent understands it. This is not true. I found many babies being fed incorrectly. Once, when I pressed to see the hospital formula, it was located filed away as some precious document with the birth certificate."

The hospital-based maternity services, established through agreement between five South Jersey hospitals and the State Department of Health, proved so satisfactory to both patients and hospitals during the 1963 season that steps were taken in early Spring of 1964 for renewal of this arrangement.

The need for such services by the migrant population was underlined by the high incidence of obstetrical problems and congenital defects revealed by individual bills in 1963. Through an extension of the Mental Retardation Act of 1963, which recognized the close relationship between mental retardation and lack of proper maternal and infant services, additional funds became available through the Maternal and Child Health program of the Department to provide and improve maternity services for the migrant group. As a result, it became possible to extend the 1963 agreement to more hospitals in the migrant areas throughout the State.

The arrangements for reimbursement permitted the establishment of recommended standards for prenatal care, including statement of the philosophy "that good prenatal care not only encompasses the patient's medical, emotional, social and economic needs, but that such services should be provided in a sympathetic, dignified and understanding manner." These standards emphasized the importance of parent education, the availability and use of the hospital's professional medical social services, nutrition consultation services, emergency services, and referrals as part of a comprehensive maternal and infant program.

Under agreements with eight voluntary community hospitals in six (6) counties, 61 women received obstetrical care. The total charges for this service were $7,665.70, of which $1,037.70 were paid by the patients themselves and $6,566.80 were eligible for Maternal and Child Health Funds. Only $103.40 remained as unpaid balance on the books of the eight hospitals participating in the program.

DENTAL SERVICES

> "Emergency dental care was available for all who needed it, but very few accepted it."

Dental health education for both migrant children and adults was the major aim of this year's migrant dental program, closely linked with the related aims of expanding dental restorative services to children in the migrant schools and providing emergency dental care for migrant adults through facilities in the community.

The educational objective was achieved through the employment of a registered dental hygienist, a candidate for a B.A. degree, who received her certification as a dental health instructor upon completion of this period of field training with the New Jersey State Department of Health. Working with the coordinator of migrant dental services, she succeeded in planning a series of teaching programs tailored to a variety of age-levels and situations, involving imaginative use of stories, films, posters, discussion sessions, and large-scale models of the mouth and toothbrushes.

These educational programs were well rehearsed and then brought directly to the migrants by a group of dental students, including a June 1964 graduate who became licensed during his employment with the migrant program. Significant among the teaching materials used was a Spanish-speaking film on dental health borrowed from the American Dental Association, particularly appreciated by migrants with Puerto Rican backgrounds.

The educators were equipped to do their job with more understanding by advance orientation in the history of the migrant program in the State, including the working of the migrant schools, the role of the volunteer agency in the program, and direct observation of migrant living conditions on three farms.

Four clinical dentists and dental assistants were assigned to the migrant summer schools and the Vacation Bible School in Freehold. Gradually, the children's fear of dental treatment was overcome, and it was possible to perform a total of 412 examinations. In the course of 850 visits, 123 extractions were performed, 304 fillings completed, 400 cleanings and 295 fluoride treatments given. Time prevented the completion of more than 36 per cent of necessary work, or 149 cases. X-ray equipment was not available because of lack of funds.

The dental health educators instructed the children in the dental clinics at the migrant schools while they waited to be treated by the dentist. Dental health education programs were also given during assembly meetings in the school auditorium. The educational program helped the children learn about the importance of their teeth, proper diet, and correct tooth-brushing. Most children had never before owned their own toothbrushes, and treasured those given to them as part of the program.

Hopefully, it may be possible in the future to bring these dental treatment and education services to the tent camp program for migrant adolescents and young adults conducted at Rosenhayn by Glassboro State College.

Dental screening was performed by a licensed dentist at the evening clinics and dental emergencies were referred to private practitioners for treatment. Dentists from local communities, working in their offices under agreement to treat migrants referred by public health nurses, rendered a total of 83 treatments at a cost of $415.00. Emergencies had to be limited to cases where care was needed as a life-saving measure, to control bleeding, to relieve pain, or to control infection. Even when emergencies existed, it was found difficult to convince many migrants to accept referral for treatment. The dental coordinator observed: "No one was denied emergency treatment but everyone offered such care did not accept it."

MIGRANT CLINICS

"To present a new idea to a group of migrants
who must travel many miles to participate, and
get participation is an accomplishment in itself."

Migrant health services were made available to 2,375 workers in 71 clinics in eight counties in 1964. An additional 783 persons required the services of a physician and nurse. This year's schedule included two clinics held for the first time in Gloucester County. Clinics of 1964 were arranged at camp sites and farms so that migrants might feel a greater sense of privacy than was possible at last year's mass sessions.

The broadened clinic program offered immunization procedures, tine testing for tuberculosis, on-the-spot Rapid Plasma Reagin card testing for syphilis, dental health screening, physical inspection by special arrangement, literacy tests and nutrition demonstrations, and the distribution of powdered milk samples. Representatives of the Social Security Administration and Planned Parenthood added to the range of services offered at some clinics.

Physical inspections were given to 334 persons, 76 to persons under 15 years of age, 201 to persons 15-44 and 57 to persons over 45.

Immunization against smallpox was given to 15 persons, all of whom were under 15 years of age. This was done without incident in Middlesex County.

Of the 1,714 tuberculin tests administered in the clinics, 1,465 were read either in the clinics or by Public Health Nurses in the field. In testing for tuberculosis, a great deal depends on the migrants' understanding of the need to read the tuberculin test 72 hours after it is given. The frequent difficulty encountered in finding the men accounts for the lower number that were read. Twenty-four persons were X-rayed for tuberculosis at the clinic sites. Two cases of active tuberculosis have been reported as a result of this screening activity.

Public health nurses working under a physician's supervision in the clinic setting served 1,505 migrant workers or their dependents.

Type I Oral Poliomyelitis Vaccine was administered to 1,535 persons in migrant clinics. Ten percent of recipients were under four years of age. A total of 1,243 recipients were over 15 years of age. Type II Oral Vaccine was given to 191 persons of all ages, and 68 received Type III. Middlesex, Monmouth and Salem Counties had programs that fed over 260 persons each. In Monmouth County, nearly 400 persons participated.

Diphtheria Tetanus Toxoid was given to 1,624 persons, of whom three-quarters received their first dose. Male recipients made up 75% of this group. While the number of persons receiving second and third doses is small, it is gratifying to note that over 250 received booster doses. Three hundred seventy-three (373) persons received Diphtheria, Pertussis, Tetanus-combined toxoid. The majority of recipients were children under nine years of age. A few adults received this toxoid without apparent severe reactions.

A serologic test for syphilis was given to 1,629 persons. Of these, 142 were found to be reactive and were brought to examination. This was accomplished by using the Rapid Plasma Reagin Card Test. Among the 142 reactive persons were 18 who were brought to treatment for newly discovered syphilis, and 78 diagnosed as having had syphilis and having had adequate therapy.

A special study of the Rapid Plasma Reagin Serologic Test for Syphilis was undertaken at 13 clinics in Monmouth, Middlesex, Burlington and Mercer Counties between June 13 and September 30. A total of 649 migrant patients were tested. More than twice as many males (448) as females (201) attended, of whom most (626) were between the ages of 15 and 64. Results of the RPR test were obtained in twenty minutes. Patients with reactive RPR tests were quizzed by a Venereal Disease Investigator as to history of lesions, last non-reactive S.T.S. and previous treatment for syphilis. If the patient were previously treated for syphilis, the case would be closed. Patients diagnosed as having early syphilis would immediately be treated and interviewed, as were patients unable to be diagnosed. If diagnosis was not possible, the patient would be serologically followed.

All patients with reactive RPR Card Tests, regardless of diagnosis, were followed with a Venereal Disease Research Laboratory test. Of the 649 patients tested, 81 were found to be reactive. Five were treated for early syphilis, and 35 were diagnosed as previously treated for syphilis. Forty were dispositioned to be not infected after the V.D.R.L. test was found to be non-reactive. Through the cooperation of the head serologist at the State Laboratory, the results on all V.D.R.L.'s submitted by migrant clinics were obtained within two hours. One patient was found to be biologically false positive. The correlation of reactivity between the RPR Card Test and the V.D.R.L. on patients diagnosed as having syphilis or previously treated for syphilis was one to one.

Three hundred and forty-two (342) persons were referred by the clinics to other facilities for service of tuberculosis follow-up, dental care, health counseling, etc. One hundred and seven (107) were referred for follow-up of tuberculosis screening results to hospitals and clinics for X-ray examinations. Ninety-one (91) were referred to public health nursing agencies and other agencies for health counseling. Venereal disease and dental referrals account for 76 referrals. Fourteen (14) pre- and postpartum referrals were made. Other referrals were made in small numbers for eye diseases, crippled children and mental retardation services, treatment of intestinal parasites, care of injuries, medical illnesses, e.g., diabetes, hypothyroidism and other conditions such as umbilical hernia.

Tests for literacy were introduced at clinic sessions to determine the migrants' capacity to read the health education material. Fully one-third of the persons from Puerto Rico tested failed the simple test.

The success in clinic service was directly related to the continuing activities of the public health nurses and the new activity of the health educators, who used every opportunity to teach the concept of preventive medicine and to encourage migrants to attend the scheduled clinics. As a result of concerted health education work, the Salem clinics of 1964 were better attended than those of any previous year.

The nurses developed their own effective channels of communication to win acceptance of clinic services. Farmers' wives who were active in parent-teacher activities and who had migrant workers on their farms were solicited as volunteer clinic workers. As a result of their influence on migrant workers, they succeeded in building clinic attendance.

General observations were that migrants, farmers and the local community all shared a heightened awareness of the importance of the clinics. Indeed, helping at the clinic was occasionally construed as a status symbol; several farmers asked about the possibility of holding a clinic on their farms.

With all the difficulties weighed in the balance, including the problems of transportation, of communication, of fear and superstition that had to be overcome to persuade the migrant to accept injections and blood tests, this year's success in bringing the migrant to larger scale participation in clinic activities can be recognized as a genuine accomplishment. A series of tables are attached as appendix.

MIGRANT SCHOOL HEALTH SERVICES

> **"One little boy said, "Look what I learned in school." He showed me how he tied his shoelaces and how he put his coat neatly over the chair when it was not on his back."**

Health services provided by the State Department of Health to almost 400 migrant children registered in four migrant summer schools in three New Jersey counties were part of the total educational program planned and administered by the State Department of Education. This year's enrollment was higher than in previous years, although daily attendance was lower than total registration. About 45% of the children had previously attended New Jersey's migrant schools.

School health services were carried out at the Mary Shoemaker, Cedarville, Deerfield and Cranbury schools by a school nurse and physician at each school under the over-all leadership of the Supervisor of Nursing for Migrant Schools and the State Health Department's Nursing Consultant in Maternal and Child Health. The school physicians were employed by the Department's Bureau of Maternal and Child Health. The Department also employed a dentist and dental assistant for each migrant school.

In a comprehensive program of protective immunization, diphtheria, tetanus, pertussis and polio immunizations were given to all students not previously immunized. D.T. immunizations were given to 179 children, 133 received D.P.T. immunizations, and 372 doses of polio vaccine were administered. Three hundred twenty-eight children (328) were Tine-tested in the annual summer school screening for tuberculosis, with 19 positive reactors found. Most of these were X-rayed and given follow-up as needed. This year, because of the great need for smallpox immunization among this group, a special effort was made to vaccinate in all the schools. Smallpox vaccine was given successfully to 112 children. As in past years, the presence of impetigo and other skin conditions prevented some vaccinations.

All children were weighed, measured and checked for skin lesions or rashes, for ringworm of the scalp and for a vaccination scar. They were given vision and hearing tests, general physical examinations, dental examinations and dental care as needed. More hearing and speech problems were detected than in previous years. Referrals were made to the Hearing and Speech Clinic at Cooper Hospital, the Crippled Children's Commission, the Florida State Department of Health, Princeton Hospital Eye Clinic, Middlesex Hospital Orthopedic Clinic, Fitkin Hospital Orthopedic Clinic and other sources of care. A psychological test was arranged for a boy with a difficult adjustment problem.

Migrant Public Health Nurses were given names and camp addresses of the children with positive tuberculin tests, Mantoux tests and X-rays, and with impetigo or ringworm of the scalp for follow-up of other family and camp contacts. Follow-up was sometimes extremely difficult because

of migrant mobility and time-consuming situations involving out-of-state communications. Among positive tuberculin test reactors, for example, were three brothers, a half-brother and a cousin, ranging in age from three to six. These children were traced by a concerned school nurse to a family with a 16-year-old daughter in a Florida sanatorium with active tuberculosis. The children, it was discovered, had been on INH and PAS in Florida, but had discontinued it. They are to report to the physician for examination as soon as they return to Florida.

Another family in which three children had positive tuberculin reactions moved and left no forwarding address before suitable medication could be secured. In this same family, five children had impetigo, one had trench mouth, and one had ringworm of the scalp. A hearing clinic appointment had to be cancelled for a child in this family when it was discovered they had moved. Attempts to locate them were made through the public health nurse, the other migrant schools and other sources.

Treatment with Fulvicin, dispensed through the schools, was given for 23 cases of ringworm in the Deerfield Township school alone. All cases of impetigo showed improvement after treatment and some were completely cleared. At Cedarville, 148 treatments for skin diseases were given during the five-week period. Wherever possible after the first few treatments by the nurse, children with impetigo were shown how to treat their own skin lesions, and were taught improved habits of cleanliness, to help make them more responsible for their own care. Besides daily attention to skin lesions, nursing care was given for cuts, nosebleeds, colds, insect bites, lacerations and scraped knees.

As a result of a mild outbreak of measles in the Woodstown school, gamma globulin was administered to all the children in one classroom. Known cases were followed up and all family contacts under one year old as well as all pregnant women were referred to local physicians for gamma globulin.

Through their daily contact with children and their personal interest in their welfare, the school nurses were in a position to observe needs and render services, help and education that were lacking in most migrant home situations because of poverty, ignorance and the absence of suitable facilities. Nursery-age children received clean clothes and were bathed daily and shampooed three times a week, a course of action which quickly healed many skin sores and infections. Shoes and clothing were obtained for needy students, and gym suits, sneakers and socks for those entering high school. Four pregnant women and five new mothers were provided with baby clothes. Older students were taught to wash and iron their clothes and take better care of shoes and clothing. Educational material in Spanish was distributed, and separate discussions of personal hygiene and cleanliness were held for groups of boys and girls. As indicated in the section on dental services, the dental educators gave each child a dental kit and individual instructions in tooth brushing.

The school lunch program again in force this year supplied a high-protein, high-carbohydrate lunch, and milk and cookies every morning. Significant weight gains were observed in 83 children during the five-week school session. The migrant children in summer session seemed to work better and be more relaxed than those who stayed on into regular winter sessions, apparently because of the absence of competition with children from a different social and economic group during the summer, as well as the absence of clothing rivalry. One of the many indications of the need for day-care arrangements for the youngest children was the fact that so many of them fell asleep in school.

The vital contributions of the summer schools underlines the need for their continuation and expansion. A census made in Cumberland County indicated that enough migrant children are concentrated in one section of that area for a school to be located there next year. Teachers and nurses must continue aggressive recruitment of students from the camps, and parents must be effectively informed of the availability of both summer and winter school for all children as long as necessary immunizations have been completed. Migrant parents must be persuaded to enroll their children and keep them coming every day that school is open.

PUBLIC HEALTH NURSING SUMMARY

> "Dear Mrs. K:
>
> How are you? I am thanking you very much for what you have did for me. Myrtis is using her artificial eye. The one that she had kept fallin out. Willie B. and Edward and all the rest of the children is doin fine."

In 1964, as in the previous four years, Public Health Nurses assumed responsibility for a large part of the health services rendered in the Migrant Health Program. For the fifth consecutive year, the New Jersey State Department of Health has provided nursing service through contractual agreement with voluntary public health nursing agencies, Burlington County Public Health Nurse Association, Cumberland County Board of Chosen Freehold, Middlesex County Visiting Nurse Association, Monmouth County Organization for Social Service and Princeton Visiting Nurse Association and local health departments.

Public health nursing service continues to be a sparse commodity in the five Southern most Counties of the State. Five public health nurses and a nurse supervisor were employed directly by the State Department of Health on a temporary basis and assigned to the Migrant Health Program in this area. The four school nurses employed by the State Department of Education in the Migrant Schools were offered and accepted supervision by the nurse supervisor. The nurses employed for field service had their office space in the Woodstown Office, a valuable asset in rendering service in Salem and Gloucester Counties. All of the nurses were aware of the importance of evaluation of the total Program and have been free in expressing their feelings, observations and recommendations.

This summary is a composite of all the nursing reports from all agencies submitted individually and collectively.

Again this year the migrant area was canvassed to a greater extent by all the nursing staff. Farmers and crew leaders were visited in an effort to enlist their cooperation, ascertain the number and time the workers were to arrive, as well as, serving as a case finding device. In one or two instances the pre-season visiting was interpreted as over solicitous. The information obtained was often inaccurate.

In all areas the nurse was well accepted and many of the farmers and crew leaders were familiar with the service from the previous years experience.

Some community resistance and criticism still exists toward the migrant worker and the Program. In a few areas the chief complaint was that too much was being done for the migrants and nothing for the residents of the State.

As a whole, this did not appear to be a problem. In fact, the Migrant Program has served to demonstrate what can be accomplished for members of a low socio-economic group when community participation and local and State health officials provide leadership.

The nursing agencies serving the Central portion of the State all indicate and predict a gradual change from a rural farming area to a suburban semi-industrial community. Housing developments and industrial sites are replacing farms. Each year there are fewer farms and less workers and many of the workers used are day-haul. This is and will continue to affect nursing service. Travel time is increased and the number of persons benefiting from the service continues to decrease in spite of the fact that nursing time is increased. This changing picture is also influencing the year-round case load. In one particular community, homes that had always been occupied by white resident families are now being rented to negro families who had once been migrant workers. This transition was not observed in the Southern counties.

There was a unanimous opinion that more children were found that had completed the initial immunization series than in the past. Although the difference was not significant, more families were able to produce the Health Record than in previous years.

For the most part, health education was done on a one to one basis between nurse and migrant. The most receptive audiences were parents of small children. Health teaching was directed primarily towards safety, nutrition, personal hygiene, dental health and sanitation. Regardless of the reason for visiting, health education was always included in the visit. Teaching opportunities were constantly presenting themselves during camp visitation and on the spot teaching and demonstration was the method most successful. With the exception of one nursing agency, on the spot education and interpretation was the method employed with growers and camp managers. In Monmouth County an unsuccessful attempt was made to bring growers and camp managers together for planning.

A considerable effort was made in pre-planning by one agency for Tine testing. Information on Tuberculosis was given to growers, crew leaders and migrants. The value of having migrants involved in pre-planning was appreciated and attempted, but actually in order to plan effectively pre-planning must occur early and the migrants did not arrive early enough for the planning.

Again all nurses indicated that most success was achieved in orientating volunteers at the time of their assignment to a specific task.

More volunteers were used for transporting patients to community facilities than ever before but by no means has the increase been sufficient. Transportation still remains a serious problem. Volunteers are willing and anxious to serve at the clinic.

A strong and outstanding feature of the Program was the attendance of local private physicians at the community clinic held for migrant workers. The nursing staff of all involved agencies have repeatedly stated the importance of this participation. The physician served as another interpreter of the Migrant Program to the community and added much to the acceptance of the migrant in the community.

Migrant workers did not, as a rule, remain in the area because of health services. The primary reason for the migrant being in the area was "work" and this took top priority. If the availability of a job necessitated a move, the health facilities and need for follow-up of a medical problem did not usually delay the move.

One family who had been the recipient of much service did take the time and make the effort to write to the agency to thank the nurse for all she had done to help them. The letter also informed the agency of the new address and of the plans they had to remain in Florida. An interstate referral and case summary was forwarded to Florida and the family will continue to receive nursing follow-up.

Several post cards have been received from migrant families served informing the nursing agency of a new address when the family was settled.

More requests for service have been made by farmers this year than ever before. Pregnant wives of migrants were anxious to establish contact with a doctor or clinic for prenatal care and often sought the nurse for guidance and assistance with registering. One family in Salem County made plans "to stay in the area until after the baby was born", because they liked the service of the Salem Hospital.

Ignorance of preventive health care continues to be the rule rather than the exception. Medical care for the most part continues to be sought when pain and/or an emergency situation exists. Far too many workers remain unfamiliar with the need and purpose of immunizations. Frequent health appraisals of infants and children, relationship of poor personal hygiene to certain skin infections, the importance of prenatal care and significance of a tuberculin reaction are a few of the areas where educational efforts have been emphasized in the past seasons and continue to be prime educational targets. This situation is not restricted to migrants however.

Several cases of measles were diagnosed in young children. In one area seven cases were seen in one camp alone. Atmosphere temperatures hung in the 90's and body temperatures soared to 104°F. In discussing nursing care with the parent, the nurse discovered that the mother gave sips of warm water only, no cold liquid and there was fear to sponge the body with any liquid. This particular situation provided many opportunities for health education and home nursing (taking a temperature and reading the thermometer, doing a body sponge). All the cases recovered nicely without complications to date. Gramma globulin was administered to all infants in the camp.

Weaknesses:

The nursing staff was requested by the State Department of Health to complete at the time of the visit a report of individual service. This form was to be completed on every person visited and every time a visit was made. Most of the nurses objected to filling out these reports because it was time consuming. One nurse reported that when the farmers saw forms being completed they associated the nursing service with the camp inspection of the Migrant Labor Bureau and occasionally this hindered the visit. All were pleased that they did not have to tabulate figures at the end of the season.

Follow-up of referrals made, leave much to be desired. Very seldom was a reply received after a referral had been made to a clinic or private physician. Only with constant proding of the clinic or physician was a report of the visit received. Too often the nurse did not take the trouble to do the proding.

Social service referrals were scarce and again leave much to be desired.

Language barriers presented a problem to some nurses, others felt that an interpreter would be helpful but means and ways could be found to communicate.

It is interesting to note that there appears to be on the part of several of the nurses, a subtle undertone and questioning the delay of the migrants to assume more responsibility for their families' health. This situation will be used constructively and the nurse encouraged to question why. Perhaps this situation may be due in part to her own need to do everything she can for her patients.

REPORT OF INDIVIDUAL SERVICE

Early in the spring of 1964 efforts were directed to the development of a reporting system which would provide information on individual service rendered to migrant agricultural workers. A series of reporting forms were prepared and tried in the field with varying results. In mid June a decision was reached to accept the form then in existence and apply it to services rendered by State Health Department personnel and the personnel of contracting agencies. The form was presented to representatives from all agencies who would be serving the migrant during the summer of 1964 at an orientation session on June 29, 1964.

The following report has been developed from an analysis of the reporting system put into operation on July 1, 1964. The reporting system functioned in nine counties of the State, Atlantic, Burlington, Camden, Cumberland, Gloucester, Mercer, Middlesex, Monmouth and Salem. It was used by Nursing Agencies in all of these counties. A total of 1,833 persons were reported as having received individual service in these counties.

The program operation of the individual county agency influenced in some degree the numbers of persons who were reported as having received individual service. For example in Monmouth County where 832 persons were reported, it would appear that 446 of these persons were included as receiving the individual service because the policy of the agency was to administer and read the tuberculin test on an individual basis in the camp. In other counties this same type was counted as a clinic service and therefore was not counted as an individual service.

There were 1,119 males and 714 females. The percentage of males in this group averages 61%. A low of 7.6% males was observed in Atlantic County, where only a small number of persons were seen. Other low levels of 35 and 47% males in Middlesex and Salem Counties were observed because in the course of camp location and case finding activities nursing staff came in contact with more women in the camps and learned of their needs in the daytime when the men were working in the fields.

Among the 1,833 workers observed there were 70 whose age was not determined. There were 581 below age 15. In the overall 63.4% of the persons receiving individual service were over 15 years of age. Low percentages of persons over 15 in Atlantic, Gloucester, Middlesex and Salem Counties reflect camp location activity, case finding activity and association with school health activities. These factors put the nurses in contact with a lower age group at a time of day when they did not have an opportunity to observe or serve the male members of the camp. In Cumberland and Monmouth County clinic visitations and testing activities were conducted in the camp at a time when it was known that almost all of the camp members would be present. This resulted in a higher percentage of male workers, who required and received individual service.

Sixty-eight percent of the workers observed came to New Jersey with a crew leader.

Only 7.0 percent of those served in Gloucester County were associated with a crew leader. Where as in the small group from Mercer County, 92 percent were associated with a crew leader.

The workers came to New Jersey from 19 states and the Commonwealth of Puerto Rico, 1023 persons came from Florida. Puerto Rico was the source of 242 additional persons. Persons coming from different states were studied concerning their relationship with a crew leader. Wide variation occurs from state-to-state. Ninety-one percent of these from Georgia are crew leader associated where as only 29.0 percent of these from Puerto Rico have ties to crew leaders.

Many of the workers received repeated visitations for service and thus it is possible that they may have been seen by several different professionals.

Of the 1,833 persons 1,819 were seen at least once by a public health nurse. Thirty-seven persons received a visit and service from a health educator.

It is interesting to note that Health Education services were rendered in Cumberland, Gloucester and Salem Counties where direct efforts at in-camp health education activity were undertaken. This observation is not to be construed as a measure of the total number of individual services rendered by health educators. Careful inquiry has indicated that the health education staff became engrossed in its own developmental activities that are reported elsewhere in this report and that they overlooked the preparation and submission of a report of individual service on each person with whom they had contact in the camp and on the farm. In similar fashion while it is reported that 14 persons received service from the Social Workers on the staff, it became apparent that the individual report of service did not adequately serve the needs of the social worker in the field. Serveral discussions were held concerning the desirability of submitting the form.

In view of the pressing needs for immediate action in many social service problems it was deemed advisable to accept those forms that came freely and avoid an administrative device that might cause the social work activity to bog down in red tape.

The purposes for which visits and individual services rendered made were recorded. The most common service rendered was tuberculosis screening. In this service the public health nurse administered the tuberculin test in the camp and read the results 72 hours later. This activity provided an opportunity to meet on a face to face basis, as many migrants as the agencies have time and manpower to achieve. This provided an opportunity to question each person about his or her state of health and therefore contributed to a massive case-finding effort geared to find tuberculosis and other disease. Eight hundred and seventy-nine persons were served in this activity. Practically all of this activity occurred in Monmouth County where 813 persons were screened.

Cumberland and Salem Counties were involved in thistype service to small camps that were distant from central clinic operations.

The next purpose for which visits were made and services rendered was health counseling. In this case persons seen at the clinic and observed on the farm were visited to assist in solving their apparent health problems. This also included visits to stimulate complete immunization of children and attendance at screening clinics. Four hundred persons were served, 156 in Gloucester County where this activity appeared to be most prominent, 123 persons in Salem County and 60 persons in Middlesex County.

Seventy-four persons received individual services related to Acute Communicable Disease, 52 were in Burlington County where immunizations were given at the time of a camp visit. Seventy-four persons also received services related to the diagnosis and care of tuberculosis. Burlington County recorded 59 persons who received the service.

Forty-six persons were visited for prenatal services and thirty-six for injuries.

When a visit for service was made the professional worker was responsible for making a diagnosis of the most important need in the management of the migrants' health problem. An estimate of need was obtained on all persons served. There were variations in interpretation of need from agency to agency.

This variation does not seriously affect the overall situation. In all counties the need for nearly all persons was assessed by the nurses to be "other" than out-patient, in-patient or physician services. There were 1453 persons recorded in this category. The most important factor in this category was "tuberculosis screening" service. This service was limited almost exclusively to Monmouth County where 813 persons were screened by visits and service in the camps. When tuberculin screening was done in the camps there was a need to return to the camp 72 hours later to read the tuberculin reaction.

The action taken by Public Health Nurses in response to need were evaluated. In the overall, 641 persons were referred to other agencies, 340 for services associated with tuberculosis screening. Three hundred and twenty-six were provided with health education, 122 with immunization, 8 casework service and 33 nursing care. Seven hundred and three received "other service" primarily associated with tuberculosis screening for 533 persons, this involved the interpretation of the tuberculin test.

There were 290 persons whom the nurses felt needed out-patient services, 254 were referred for care, 18 were provided with health education materials, 2 received social case work and 4 direct nursing care. In this category of need 146 referrals were made to hospital out-patient clinics and X-ray departments in association with tuberculosis screening. The majority of these occurred in Monmouth County.

Eight of 13 persons judged to need in-patient care were referred. These included a prenatal, a poisoning, a mental patient, a cardiac, a patient seen for health counselling and 3 with other conditions. Seven of the 13 cases referred to hospital for in-patient care were from Cumberland, Gloucester and Salem Counties.

Sixty-four of 77 persons judged to need physician services were referred. Referrals were for eye disease, injuries, dental care and 28 miscellaneous conditions. Six persons seen for health counselling were referred to a physician. Sixty of 64 referrals to physicians were made in Cumberland, Gloucester, and Salem Counties.

In the "other" category of need, 315 persons were referred. One hundred and ninety-four as the result of tuberculosis screening generally to a mobile chest unit. In Monmouth County there were over 100 referrals to the mobile chest unit. Eighty-two persons seen for health counselling were referred generally to future migrant health service clinics.

There were 641 referrals, 279 were made to local hospitals, 5 to social service and 357 to other services such as the screening clinics, private physicians and other local agencies. This element of activity requires further clarification in the coming summer.

It was anticipated that as field staff came in contact with the migrants that social needs would be uncovered that would require social service, public welfare, and other forms of assistance.

In all only fifty persons came to attention, 15 who required casework and 28 who were judged to have financial need. The distribution by counties reveals that most of the persons were identified in Cumberland, Gloucester and Salem Counties. This does not indicate a major social need in these counties but rather a lack of perceptiveness in the other counties. In terms of action taken on behalf of the 50 persons, it is interesting to to note that 11 were referred to the Hospital, 10 to Social Service and 29 to other resources. The lack of referral to Public Welfare is hardly consistent with the recording of 28 persons who had financial need.

This analysis reveals that the interdisciplinary development involving social service is still at a low level and that much must be done to obtain a true insight into the social needs of the migrants.

Many of the Migrant Agricultural Workers received individual service on several occasions. Eighty-nine percent received 1 or 2 visits, 10.9% received visits ranging in number from 3 to 15. The frequency with which 3 or more visits occurred in the various counties is quite stable with the exception of Middlesex County where 1/3 of the migrants received 3 or more visits.

The 1,833 workers received 3,278 person visits during the migrant season in New Jersey. The 3,278 person visits have been distributed according to frequency. The largest grouping of 1,768 visits were made to persons who were seen on two occasions. The largest single contribution to this value comes from Monmouth County where two individual visits are involved in the administration and reading of the tine test. Twenty-three percent of the total person visits were conducted on behalf of persons who were seen three or more times.

In analyzing the type of care or service rendered it is apparent that 1,401 person visits were made in rendering nursing care to migrant workers. Five hundred and twenty-one person visits were assigned to health education and 728 were recorded as providing a referral to some other agency or service. In analyzing this distribution it became apparent the interpretation of terms and assignments to categories varied among the agencies and even among professionals in the same agency. Further work on this type of analysis is required in the future years to establish more clear cut criteria.

It is to be recalled that only 33 persons were recorded as receiving nursing care. The 1,401 person visits for nursing care does not coincide with that finding. It must be stated that administration and interpretation of a tine test. Administration of immunizations were counted as nursing care. The discrepancy is one of interpretation of administrative detail rather than one of service.

Seven hundred and twenty-eight person visits were associated with the referral of persons to various community agencies and services. It is to be recalled that 614 persons were involved in referral, therefore, more than one visit per person was needed to effectuate the referral.

On some occasions several visits had to be made to the same patient for the purpose of making and clarifying arrangements for admission to hospitals or for arrangements to meet the migrant health clinics or the mobile X-ray unit. It appears that the most important point to which referral must be made is to the community hospitals for out-patient service or for in-patient admission. This value is weighted in part by the necessity to refer persons for 14 x 17 X-ray examinations to tuberculosis hospitals or to community hospitals for this service. Where pre-natal clinics are held in hospitals, here again we have another factor requiring referral to a hospital for service.

In some instances the patient concerned had already been referred to a hospital as a result of a school clinic examination and the nurse visited to make necessary arrangements for the proper admission of the patient to the hospital. A number of visits revealed the need for private physician services. This frequently arose as the result of referral from a clinic where the nurse was required to arrange with the patient for medical care available from a nearby private physician.

A great deal must be said in favor of the referral of migrant patients on a planned basis to private practitioners who will accept them in his office practice in the same manner that other community patients are received. This creates an attitude among the migrants that they are accepted as other people are. On future referrals the migrant is not reluctant to return at the appointed time. Reasonable success was obtained in Cumberland, Gloucester and Salem Counties where specific efforts to refer migrants to private physicians were carried out during the past summer.

Five hundred and twenty-eight visits were associated with Health Education, 326 persons were involved. A wide range of health information was provided. In Salem and Gloucester Counties visits included efforts at motivation of migrants to attend immunization clinics and to attend prenatal clinics.

The 610 visits listed as "other" included provision of health records, preparation of survey information, verification of migrant status, transportation, pathfinding to locate people and camps and demonstration of problem cases to students, other staff personnel and visitors interested in assisting the Migrant Health Program.

In spite of the observed social need it is interesting to note that only 8 person visits were concerned with a referral to a social service activity. Further, in spite of the fact that financial need was recognized there is no indication that the visits resulted in referral to public welfare.

In working with the migrant worker perception is needed to anticipate the social needs of the worker who is handicapped by ill health. All too often the worker is in dire distress socially when he comes to attention as a medical emergency. This has occured in spite of the fact that the worker has been seen by one or more professionals prior to the emergency. With migrant workers who have ill health, it is necessary not only to plan medically for their medical and nursing care but to plan socially in order that they are not deprived by financial distress, lack of housing, clothing, food and transportation. This area of social perceptiveness needs to be enhanced in future summers.

The 1,833 persons who received individual personal services were requested to produce a public health service health record that had been especially designed for migrant health services. Two hundred and seventy persons or 14% of the total gave evidence of having the public health service record.

In the course of the personal individual service 864 public health service records were issued. Thus records were given to 47% of the individuals served. This does not mean that only 864 records were given to persons in New Jersey during the past summer. In general in some counties the records were issued primarily at the time of clinic services rather than at the time of an individual service. It appears to have been standard practice throughout the clinic area that an individual public health service record be given to each participant in clinic activity. It is important that this effort to seek and require the public health service record continue. The more frequently it is sought the more significance will be attached to it. It is equally important that we make sure that each person who is served receives a record for future use.

In the course of rendering individual service, it is important to inquire concerning the possession of a social security card. It is important that every migrant worker be enrolled in the social security system and that as much credit as possible be recorded in their account. For this reason each individual who received individual service was queried concerning the possession of a social security card. One thousand two hundred and fifty-two persons in this study group who were over the age of 15 years were questioned. Seven hundred and sixty-seven or 61% reported possession of a card. Of the 767 workers having cards, 523 or 68% were males. The possession of a card is not enough. The workers must understand that deductions from their wages need to be forwarded to the Social Security System in order that they receive credit. Spot checks have not been credited. This is a dis-service to the migrant now and in the future and deprives him of the assistance available under the social security system.

A series of tables are attached as Appendix

ANALYSIS OF SPECIFIC PROBLEM CASES
MIGRANT HEALTH PROJECT
NER JERSEY 1964

During the migrant season, nurses, social workers, health educators and others serving the migrant workers and their families were requested to file individual reports on all aspects of problem cases which they encountered. All patients receiving maternal clinic care, all receiving laboratory, X-ray and out-patient services and all in-patient admissions were included in this system of reports.

Patients who were considered in these reports may have had an individual report of service also. This occurs specifically when there is need to verify the status of the migrant in order that a hospital bill may be paid. Many of these patients come to attention directly from the Hospitals.

While there may be some duplication in patients studied in this report and other reports, it is not considered critical.

This study deals with 594 migrant men, women and children. The following table presents the county of origin of these patients.

DISTRIBUTION OF MIGRANT WORKERS AND DEPENDENTS
STUDIED AS PROBLEM CASES BY COUNTY
NEW JERSEY 1964

County	Number	County	Number
Atlantic	10	Middlesex	23
Burlington	38	Monmouth	56
Camden	12	Salem	164
Cumberland	222	Other	13
Mercer	40	Total	594

Patients from the two counties of Cumberland and Salem comprise 65.0 percent of the total group. Both of these counties have large populations of migrant workers. The large numbers in these counties may reflect also the emphasis that was given to migrant health services this past year.

In this group of 594 cases there were 330 negro patients or 55.3 percent of the total. One reason there are so many negroes is because the negro family migrates as a whole. Migrants with families usually have more difficulties than those who migrate alone. The remaining cases were Puerto Rican. There is no data available to indicate how many Puerto Rican workers migrate with their families, however, relatively few Puerto Rican migrant families were observed.

In this group there were 285 males, 197 females and 112 children. It is important to point out that from among the 197 women, 105 received prenatal care and gynecological services. Among the children, there was 21 with records of lacerations.

The most frequent conditions among children included lacerations 21, abdominal complaints 11, upper respiratory disease 15, Hernia 7, and abnormalities of the central nervous system 8. Obstetrical and gynecological conditions (105) were most prominent among women followed in frequency by lacerations 26, and X-ray examinations. The important conditions affecting men included those requiring X-ray examinations 85 and repair of lacerations 74, abdominal conditions 18, and kidney infections 11.

SERVICES GIVEN TO MIGRANT WORKERS AND DEPENDENTS
NEW JERSEY 1964

Service	Number of Persons
All	478
General treatment with nurse visit	335
Surgery with nurse visit	15
Deliveries with nurse visit	31
Emergencies with nurse visit	53
Crippled children with nurse visit	1
Mental Health with nurse visit	1
General treatment with nurse and social worker visit	18
Surgery with nurse and social worker visit	15
Deliveries with nurse and social worker visit	3
Emergencies with nurse and social worker visit	4
Crippled children with nurse and social worker visit	1
Mental cases with nurse and social worker visit	1

Four hundred and seventy eight cases were visited by the nurse alone or in combination with other disciplines. This represent 80.0 percent of the sample. The nurse maintained contact with the cases and also with the farmers.

This group of visits are also counted under the individual service report. In many cases the nurses were involved in health counselling and verification of migrant status.

It is important to recognize that while many of these cases had social problems, only 63 received service. Many of the cases with social problems did not come to attention through lack of referral either by the public health nurse, or the hospital. It is most important that the hospital report cases immediately upon identification of the person as a migrant. This permits a social service referral and pre-discharge planning can begin immediately. A case admitted to a hospital as a migrant was severely disabled and needed long-term care from July to December. He was reported as in need of social service on December 28, 1964. The financial outlay on the part of the hospital in this case is in excess of $3,000.00. Earlier help would have relieved some of the expense.

In general this is the largest aggregation of cases compiled by this agency. The one lesson it clearly brings home is the need for prompt and efficient social service in addition to public health nursing. Only 124 of these 594 cases received social service and many of these came to attention only when the person and family concerned were in crisis. Social service must be as aggressive in case finding as public health nursing.

A series of tables are attached in APPENDIX ________.

CAMP VISITATIONS AND OBSERVATIONS

> "The more frequently camps are visited and persons are served by all professionals, the greater the opportunities for the discovery of health, social, educational and emotional problems."

A formal program of recording information about the migrant labor camps served by the Migrant Health Program was undertaken in July 1964. A special form to be completed by the visiting Public Health Nurses and other professionals on their first visit to a camp requested information concerning the source of labor, type of housing units, services provided in the camps, number of units, number of units occupied and number of persons in the camp at time of visit.

Individual service reports were incorporated into the analysis of camp visits. If, for example, the Public Health Nurse visited a camp and dealt with three specific persons, one camp visit was recorded and three reports of individual service were submitted.

Visits were made to 453 camps, or about 20% of all camps in the state. Census figures in these camps indicated a population of 5,814 at the peak of occupancy. Public health nursing service was potentially available to between 20 and 25 per cent of the migrants in the state in 1964. The largest number of persons were found in Cumberland, Gloucester and Salem counties. Crew leaders were the source of labor in 117 camps. In 212 camps, the labor force consisted principally of walk-ins. In 79 camps the men had a contract either with the Glassboro Field Service Association or the Farmers and Gardeners Association. Dependency upon crew leaders for labor varied among counties from a high of 53.5% in Monmouth County to a low of 11.4% in Gloucester County.

Observations on the type of housing units were not complete, as 90 reports omitted this information. Individual living facilities as distinct from dormitories and old converted farm houses were provided in 268 of the 453 camps. A total of 1770 housing units were located in 421 camps.

Figures were obtained for services provided in housing units in 363 camps. Electricity was provided in 358 of these. Three were recorded to be without it. An electric pump was attached to the water supply in 219 of the 363 camps. Three camps used a city water supply, indicating their proximity to an urban environment. Significantly, 34 camps had open wells. Wells in 39 camps were equipped with hand pumps of the easily contaminated pitcher-priming variety, pointing to a continuing need to determine the safety of camp water supplies. All of these camps will be specifically inspected for water safety. Hot water was supplied in 251 camps. No reply was obtained for 74. Flush toilets, relatively rare in migrant camps, were recorded in only 58 of the 363 camps. Refrigeration was reported in 271 camps. The lack of recorded observations in a sizeable number of camps, particularly in Cumberland County, may bias judgement about facilities.

In all, 1,285 visits were made to migrant camps. On the average 2.5 individuals were served per camp visit. More than half of the camps were visited on only one occasion. The number of camps visited four or more times ranged from 8.8% in Gloucester County to 41% in Monmouth County. The largest number of camps covered was in Salem County, where 291 camps were visited. It should be noted that 319 visits were made to 28 camps that received eight or more visits for service. A high number of re-visits generally occurred in those areas with the most aggressive public health nursing activity. Repetitive visits were needed for families with serious medical,social or health problems.

The Public Health Nurses and other health workers normally observe the other members of the household and their immediate environment in the course of giving service. In this way, there were 5,563 "person observations", or 1.7 "person observations" accomplished for every professional service rendered to an individual.

Based on final camp visitation reports from July first through November peak camp visitation occurred in the week beginning July 27. The level of activity is most intense in the early summer months, when camp location and clinic preparation activity are at their height. A fall-off in activity is noticed after August 17, when the nurses in counties such as Salem and Gloucester returned to their primary duties in public schools. At the end of September an increased effort was made to visit the workers to pick up conditions and problems existing at the close of the season, before the migrants returned to the South or Puerto Rico. These late visits disclosed persons in need who otherwise might have been deserted.

Level of camp occupancy ranged from .63 to .96, with the camps being used between 80 and 90 per cent of capacity throughout July and August.

Although provisions were made for recording obvious sanitary deficiencies such as poor garbage control, safety hazards, lack of refrigeration and improper food storage, very few comments were made upon the report form. The Public Health Nurse does not wish to jeopardize the rapport she has built with the camp owner by taking on the role of inspector or enforcer of sanitation. She teaches proper sanitation but does not want to become the police power of the Department of Migrant Labor Bureau.

Occasionally, when the nurse reported deficiencies informally, a second inspection by the Migrant Labor Bureau was made to give the inspector the opportunity to be the primary observer of the defects. With increasing activity and understanding of roles, it is felt that this function will be carried out more readily in the future by the nurse, the health educator, the medical social worker, and others working in the field. This will help give a truer picture of severe problems at the time of occurrence.

The gathering of information is only one objective of camp visits. The success of a visit depends on the communication established between the representative of the health program and the grower and migrant. Each visit is an opportunity for health education. Health education activities involving the grower were undertaken at 301 of the 453 camps visited, and health education of migrants at 270 of the 453 camps. As a result, growers called for service more frequently, and migrants were able to benefit more completely from public health nursing visits.

"The more frequently camps are visited and persons are served by all professionals, the greater the opportunities for the discoveryof health, social, educational and emotional problems."

Tabulations of information are attached as appendix ____________.

MEDICAL SOCIAL SERVICES

> "The social worker approaches the matter on the basis of the right of the needy to receive help under the law. There is a certain dignity in this approach, because it emphasizes that the needy are the equals of the giver, and that both the giver and the needy are equals before the law and society. I believe very strongly that we should dignify the people."

A brief backward look provides a focus for the assessment of the progress made in 1964 and the preparation of plans for the next operating period.

The medical social worker joined the Migrant Project on July 1, 1963. The function and responsibilities of the social worker were spelled out in the project plan but the role of the social worker in this public health program required development.

The first months were spent in orientation, learning of the structure and function of the New Jersey State Department of Health, the place of the Migrant Health Program in the Division of Preventable Disease, the interaction between the various disciplines in the Division and within the Migrant Health Project, the image of social workers held by the Public Health personnel, and the Migrant Health Project Staff, the climate within the Department, the Migrant Health Project itself and the rural communities of the State.

Initial experience soon made it obvious that the going would be upstream in the rural areas where seasonal workers were involved. It appeared that it would be difficult to convince New Jersey communities that every human being has the right to services and experiences which cultivate and conserve his resources as a human being. One of the first steps was to reactivate humanitarianism in community relationships by developing direct communication between individuals.

Later in the first year, in February and March 1964 the medical social worker visited in Florida to learn of services rendered by the County Health Departments to the migrant workers who come to New Jersey each year fom Broward, Palm Beach, and Dade Counties. A brief visit to the Commonwealth of Puerto Rico gave an insight into the background of the Puerto Rican migrant who comes to New Jersey under contract each summer. In addition it provided and opportunity for the social worker to understand more fully the plan for social welfare in Puerto Rico and to become acquainted with the principal officials involved in health services. Steps were taken to recruit a Puerto Rican medical social worker and a Puerto Rican Health Educator for the project in New Jersey.

The 1963 goals proposed to foster communications between the Migrant Health Project, and the community health and welfare agencies, farmers and agricultural workers, in order to promote a mutual understanding, a warmer climate, and better services through local resources for the workers who serve the agricultural economy of New Jersey.

The goals proposed to assess the nature and extent of needs for social casework service among seasonal workers and their families, the availability of community health, welfare, recreation, educational and spiritual resources available to non-resident farm workers.

The goals proposed to determine the accessibility of migrants and their families for social casework service treatment and the readiness of farmers and crew leaders to tolerate social workers and to participate in planning when desirable for the welfare of their migrant employees.

The goals proposed to assess the attitude of the various farm and non-farming communities in New Jersey in those sections where seasonal workers reside during the crop season.

The first goal was approached through substantial contacts with various voluntary public health and welfare agencies, hospitals, the clergy, local civic organizations and leaders, State and local police departments and other agencies in the central and southern State Health Districts.

The second goal was approached through a demonstration of direct casework service in which 29 live cases were carried and about 20 consultations were given to public and voluntary health and welfare agencies, the clergy and police officers. An equal number of follow up cases were carried to completion. These cases were referred by the public health nurse consultant at the end of the season upon the termination of the public health nursing services.

As a result of these efforts, it was clearly apparent that the needs of agricultural migrants included the full range of health, social, economic, and psychological deprivation problems common to all groups of similarly disadvantaged persons regardless of social or ethnic origin. Health needs were primary but competed with environmental, economic and psychologic pressures, family disorganization and personal maladjustments. More than a generic casework program was needed and that its philosophy should be geared to the public health objectives of prevention and rehabilitation. It would involve case finding, treatment, and follow up. For successful operation it would require a flexibility which could meet the life schedule of the migrant workers with a comprehensive aggressive reaching out casework service and concern for the promotion of total health.

Community attitudes were found definitely rejecting throughout rural New Jersey. It was apparent that this feeling would be modified only through a long and patient educational process involving every possible means of reaching the public. The combined effort of all interested civic minded citizens would be required and these efforts should be coordinated into an aggressive community educational experience to include the participation of farmers, crew leaders and selected seasonal workers who would be interested and capable of playing a role in such a program. Community resources for health, welfare, recreation, education and spiritual guidance were pratically non-existant for non-resident persons, particularly, for those who came as agricultural migrant workers.

It became apparent also that seasonal workers in New Jersey were not readily accepted for casework services except through a reaching-out approach and that those who were referred usually came to attention in a time of crisis.

The language barrier, cultural mores and environmental experiences were real obstacles in obtaining a mutual trust and acceptance from the workers. It was found that the services of the voluntary family agencies and other casework agencies were not usually available to the workers in the agricultural migrant stream. Therefore, the workers did not have the support, encouragement and guidance of a professional caseworker at times of misfortune when in the very true sense they did not know which way to turn. There were almost no families or other casework agencies functioning in the rural areas of New Jersey where the bulk of the migrant population is concentrated. Those that did exist were usually geared to serve the more sophisticated middle income American population who are familiar and accustomed to the counseling casework treatment methods. Moreover, the agencies charged fees, often had long waiting lists, and functioned during hours that were not convenient for seasonal crop workers.

It must be said that there were instances of good cooperation from municipal public welfare offices, usually from those that participated in the State subsidizing plan for public assistance. It was learned also that where local welfare offices were reluctant to provide material assistance, that the local field representatives of the State Bureau of Assistance were most cooperative in lending their persuasive services, usually with success.

Growers, properly approached, were not always indifferent to the welfare of their workers and that they were often receptive to participation in planning for their workers on a realistic basis.

It was observed that the operating hours of health and welfare and other helping agencies in New Jersey are not geared to the needs of seasonal workers. Their services were not available to the workers who needed them during the periods of the day when they were free to use such services. Very few municipal public welfare departments participated in the Federal Food Surplus Program, which has available foods which are badly needed by the migrant workers. It was clear that the local administration of public assistance did not meet adequately the needs of the migrant agricultural workers.

The following list of goals based upon the observations and experiences gained in 1963 serve as guideposts for the activities of 1964.

To extend social casework services for agricultural seasonal workers via a comprehensive "reaching-out" casework program geared to the promotion of total health, preventive, rehabilitative, involving case finding, treatment and follow up; staffed by full time professional social work personnel augmented by temporary caseworkers and case aides as needed.

To demonstrate a flexible facility (a mobile social work clinic) in a restricted area of South Jersey where there is a high concentration of agricultural migrants, no caseworking agencies and limited community services. Hours of service are geared to the needs of migrants and operating where most accessible.

To make available to seasonal workers those services in health, welfare, education and employment which are provided for residents by state, county, municipal and voluntary agencies.

To interpret to the community-at-large the true image of the seasonal worker as a human being with needs similar to those of residents, but complicated by mobility and by many factors beyond his control such as differences in culture, language and race; separation from family; economic insecurity and deprivation fostered by the vagaries of weather, discriminating social legistation, lack of protective labor legislation and the constant threat of creeping mechanization.

To interpret to the seasonal worker his rights within the community, and the responsibilities necessary to keep those rights.

To promote communication with and between the other helping professions and community resources in order to integrate planning and to avoid fragmentation.

To be aware of the gaps in essential services for seasonal workers, and to foster interest and efforts in filling them.

To demonstrate that these many needs of the seasonal migrant can presently be met best by having social service facilities available in the migrant health project, making the fullest professional use of social casework, social service consultation, community organization, volunteer services, and many other tools and procedures available to it.

To interpret to co-workers and the public, the true image of the Social Worker and to explain as clearly and meaningfully as possible, what social casework is and how it works.

In the coming year, the aspect of prevention is to be emphasized. Most cases have been referred only at the time of crisis. The goal should be modified
1) to orient referring sources to refer cases before the crisis occurs, and,
2) to work with the client to avoid future similar crises.

To orient social workers in other agencies to a unique but basic type of casework method, involved in the short term emergency reaching-out, multi-problem situations.

One of the principal methods used for the purpose of involving key community agencies in serving migrant needs was the organization of orientation conferences and workshops for professionals and non-professionals assigned to serving migrants.

An objective of this activity was to develop community resources which could provide casework services to help migrants in critical situations, such as, at the time of hospital admission, or at the time of their discharge.

An orientation conference was initiated for hospital medical social workers in the Central State Health District in December 1963. Those in attendance included selected representatives from other health and welfare agencies public and private. While most of the medical social workers invited from hospitals were not professionally trained caseworkers the majority of them were professional nurses. This meeting was devised to give the medical social workers an understanding of the plight of the disadvantaged workers and the nature of their total health needs, physical and environmental and psychological, and to extend to the social workers communications to available health services in their respective areas and in the hope that such knowledge would tend to improve services to hospitalized and/or clinic agricultural patients. This conference was designed to encourage the medical social workers to use social work consultation services particularly in planning for discharge or inter-hospital transfer of agricultural patients. A report of the conference is included in appendix.

A similar meeting was held in early 1964 for the hospital social workers in the Southern State Health District. This meeting was well attended by many of the leading personnel in the Southern hospitals. Particular representation was afforded in this meeting from the Bridgeton Hospital in Bridgeton, New Jersey, a hospital which provides approximately 25% of all hospital service to migrant agricultural workers. A report of this meeting is included in appendix.

The experience of these meetings was sufficiently rewarding to the hospital social workers to motivate them to request a workshop in order to continue learning opportunities regarding the servicing of disadvantaged persons from the medical and social standpoint. A workshop program for migrant agricultural workers was inaugurated in 1964.

Two workshops were held in the Central Health District on June 2 and December 2, 1964. The essence of these workshops for future planning is as follows.

1. The sum total of the meeting gave the participants a living picture of the scope and the inherent problems of the migrant health program in New Jersey.
2. Medical Social Workers became aware of the common problems of the hospitals of the Central Health District in servicing seasonal workers.
3. Hospital workers learned of certain practical steps that could be taken when confronted with the migrant patients in emergency cases.
4. This meeting crystalized a working body which wants to try out what has been learned at this session but also to seek new resources and approaches as a result of current experiences.
5. There was recognition of the rationale' of local hostility towards seasonal agricultural workers in terms of fear of increased taxes, competition for unskilled jobs, etc. There was recognition of the need for interpreting fallacies in thinking, and attitudes to the community.
6. It was agreed that the experience of the summer should be reviewed at a fall workshop; and that systematic consideration be given to all community elements and forces that could contribute to constructive approaches in dealing with agricultural workers and their families in the community.

Reports of these workshops are included in appendix.

Throughout the Spring, late winter and early Spring, exploratory meetings were held between the National Travelers Aid Association, and the New Jersey Migrant Health Project for the development demonstration of a mobile social service clinic that would be used to carry social services facilities directly to the camps on a planned schedule. A contract was completed and signed by the 1st of May and a vehicle contributed by the AFL-CIO put into service. Nation-wide publicity was obtained for this project through adequate press coverage.

It is interesting to note that the orientation conference with the medical social workers and invited guests and the interpretations made through face-to-face contact with resource personnel throughout the

State in the process of casework services resulted in tangible expressions that began to demonstrate a modification of attitude on the part of those persons and groups who appeared to be prejudiced against the migrant worker as a non-resident. The activation of the National Travelers Aid contract reinforced this beginning modification of attitude.

In the Spring the medical social worker had the opportunity to participate in a program at the Glassboro State Teachers College. At that time, the college was preparing to take over a tent school from the migrant ministry. This program was sponsored and financed by the Terrel Fund of East Orange, New Jersey for a period of 7 years. The financial support was terminated in 1963 and the State Department of Education assumed responsibility for the program. The activities of the tent school included English classes for non-English-speaking seasonal workers and vocational guidance and pre-vocational practice for teen-agers. The program should be extended to motivate both adults and youths to seek opportunities to leave the migrant stream. In the meeting on this project the social worker had an opportunity to reach another audience of workers who were concerned with the health and welfare of the migrant agricultural worker. Through this contact there developed a readiness to accept personnel of the Migrant Health Project in the tent school functions throughout the summer season.

Early in the Spring arrangements were completed with the University of Puerto Rico to employ a professional medical social worker in New Jersey as part of the Migrant Project. The social work consultant, while in Puerto Rico, had interviewed a candidate for this position. Arrangements were finally completed with the worker on August 1, and he reported for duty at that time.

This plan included a period of rotation in Puerto Rico. During that time it is expected that the worker will translate to the Migrant Health Project in Puerto Rico the social service problems encountered in New Jersey. It is expected that he describe the existing health services, public assistance, the structure of municipal government and its relationship to municipal assistance, the consultant activities of the State Department of Institutions and Agencies, and the resources available to serve the migrant worker in this State. It is expected that he will relate his various experiences in such a way that the migrant workers who come to New Jersey in the future will have the benefit of a more realistic and clear-cut orientation in order that they may understand what is expected of them as well as the services that will be made available to them in the event of need.

All casework service was provided by the medical social casework consultant during the first four months of 1964. The staff was later augmented as follows: In May the National Travelers Aid and Migrant Health Program mobile casework clinic began operation staffed with a professional casework director. In June a temporary school caseworker was engaged for the peak harvest period, July and August. She terminated early in August. This worker was replaced on August 1st by the Puerto Rican Medical Social whose first tour of duty in New Jersey ends on December 31st. He is to return on April 1st for his final commitment for the 1965 season. The adaptation of the 1964 casework staff to short-term reaching out aggressive casework with multiple problem disadvantaged groups presented a number of difficulties. It is worth nothing that none of the new staff members were experienced in short-term casework practice or in the agressive case-finding approach necessary to work with seasonal migrants and other similar groups. They were functioning in unfamiliar territory. They were unfamiliar with local health and welfare and other needed resources. They were expected to maintain a very flexible work schedule involving longer hours and more extensive travel than they had envisioned. They were unprepared for and frustrated by the negative, intolerant and hostile attitudes of the community residents, public officials and the personnel of other service agencies. These professional social workers were products of our schools of social work where the training emphasis has been on the counseling casework process and service geared to the needs of a sophisticated middle class population whose education and cultural background are far different from those of the migrants. The orientation of the workers alone posed a major problem in adapting their practice. Service to seasonal agricultural workers is based largely on the reality, and needs for immediate, survival, medical care, food, clothing, employment and housing.

The staff were soon aware that the development of a social service program in the rural communities of New Jersey is fraught with difficulty and that casework with multi-problem individuals and families of the disadvantaged group requires great understanding. They learned that a caseworker serving such severely deprived clients often must, in fact, service several cases within a single case. They learned that extensive travel in rural New Jersey is required to bring casework service to agricultural migrants in the farm labor camps. They learned of the need to mobilize local services in places where there is already a paucity of services available to the permanent residents. They learned that in public assistance restrictive regulations and hostile attitudes of residents may deny benefits to the migrant worker. They learned that the mobile clinic caseworker traveled 12 thousand miles in the first six months of migrant casework activity in his restricted area of Gloucester, Cumberland and Salem Counties. They learned that break-throughs may be achieved with certain structured professional and other homogeneous groups by conferences and workshops and by daily interpretations in the course of casework and related public information activities. They learned about the increasing and expanding needs for cooperation from public health nurses, from health educators, and sanitarians and from other professional workers in the tuberculosis, venereal disease, crippled children, maternal and child health fields. 124 requests for social services were registered through a central registry between January and December 1964. These cases were handled by the Project medical social worker (41), the National Travelers Aid, (38), and the Puerto Rican social worker (45).

Thirteen cases were admitted in January, some of these were carried over from 1963. The next cases occurred in April after the arrival of the workers. During June and July the case load increased with a peak of 22 new cases occurring in August. A decline followed throughout the fall to a low of 7 admissions in December.

Two cases admitted in July required intense case work activity for nearly three months. One worker injured in an automobile accident was diagnosed as a quadriplegic with a very poor prognosis. After many negotiations the State of South Carolina accepted the man for long term care and he was transferred. This case alone involved prolonged efforts with the hospital, the municipal welfare board, the State Insurance Liability Fund, the South Carolina Health and Welfare authorities, the County Health Department, and last but not least the patient's family.

Cases of this type create situations that are not readily solved and each effort becomes one of exploration.

In the long run cases of this type put the social worker in touch with many new agencies and resources and in this way knowledge of the program spreads. This continuing service to migrants results in a spread of information as surely as the conferences and workshops and from this acitivity the case load grows. This is healthy growth in public response.

Cases were referred from 12 of the 21 counties of the State. Gloucester and Salem Counties contributed over 30 cases each and Cumberland 19. This is due to the presence of the National Travelers Aid Mobile Clinic, the Puerto Rican Social Worker, the aggressive public health nursing staff and the field office in Woodstown, New Jersey where a Spanish-speaking clerk provided ready communication for the Puerto Rican worker.

It is of interest that cases were referred from Hunterdon, Morris, and Warren Counties where the migrant population is very low. Twelve cases were referred from Middlesex County where there is a developing relationship between the hospital, the nursing agency and the Project Social Worker. This means that increased activity can be expected and that a gradual acceptance of this service can be achieved.

There were 70 Puerto Ricans and 38 negroes who sought or received medical social service.

The larger number of Puerto Ricans in this group is probably due to the higher proportion of Puerto Rican workers in the counties from which most of the cases originated.

The larger number of Puerto Ricans involved in social service activities may be due also to the presence of the Puerto Rican Medical Social Worker and a Spanish speaking senior clerk in the Woodstown office.

The Woodstown office was publicized widely in Salem and Gloucester Counties by direct action in several different media.. As calls for service increased it became a source for increasing social service. The efficiency of this activity prompted the continuation of the office throughout the winter. It is staffed in the winter months by the National Travelers Aid. Its telephone number remains and is answered. The sign is still on the door and the NTA beacon still burns at night. In the Community at Woodstown, Migrant Health Services have made a beach head and are there to stay.

Fifty-four of the cases carried were referred by public health nurses, and 28 came from health agencies. The Commonwealth of Puerto Rico Labor Office referred 12 cases. The liaison that developed between that office and the project is quite effective. The Labor Office now has a full-time worker dealing with social problems and consultation is provided by the Project Medical Social Worker.

Limited referrals were received from local social agencies. This is indicative of lack of voluntary agencies in Southern regions serving migrants, and need for direct (face-to-face) interpretation of the Migrant Health Program to such resources where they are available.

The 124 workers serviced presented a total of 166 problems. The most numerous problems were those associated with physical health, 89 workers sought aid for this cause. Legal Aid was the next in frequency followed by Mental Health and Mental adjustment problems.

One hundred and nine cases were closed before the end of the year. In 48 cases services were completed, another 19 were referred to other agencies, 5 to agencies in other States, and thirty of the workers made their own plans with assistance.

In rendering service to 124 persons, the Project Personnel conducted 1,029 interviews, 272 with the client and 757 with collateral persons and agencies.

Half of the work was carried out on a face-to-face basis, and the other half by telephone. Once lines are established by face-to-face contact, the use of telephone becomes more effective. It does not serve an adequate purpose on first contact with persons or agencies.

Visits to social service clients numbered 265, these are in addition to those counted in the report of individual service. The majority of visits were carried out on the farms. This gave the field worker a chance to meet and work with the farmer, the crew leader and to become aware of the environment of the camp.

In carrying out camp visits it became apparent that travel would be extensive. The Mobile Clinic case worker traveled 12,000 miles in 6 months serving a restricted territory in Cumberland, Gloucester and Salem Counties.

It is important to note that 80 percent of the persons receiving social services were given direct treatment. The fifty persons for whom professional consultation is listed, received services in their behalf through contacts with significant relatives and other individuals or agencies for coordination of efforts. Eleven of those who received financial assistance received funds from the Travelers Aid. This was usually given to assist a family while an application for assistance was filed or in the case of some to return to their home base. One family was sustained throughout the illness of its breadwinner. Public assistance was obtained for 8 persons. Increasing experience in this activity provides an insight in the steps necessary to achieve success for a worthy case.

There have been a great many telephone inquires from interested individuals, agencies and civic organizations for information regarding the Migrant Health Program and its social services. Accurate account was not recorded by the staff.

All staff members have made "Public Relations" visits to various public and private agencies (1) to interpret the services of the Migrant Health Program and the social services in particular, to assess the nature of their functions in the community, and the availability, of services -- health, welfare, institutional, recreational, educational and rehabilitation services to seasonal workers.

The casework consultant has been called upon from time-to-time for guidance regarding clients who were migrants but not necessarily agricultural, who have been stranded or needed special services which the particular community does not provide.

Some contacts have resulted in requests for workshops to extend cooperation and experience of social service units in serving seasonal workers and other simularly deprived groups.

Some of these inquiries were motivated by the newspaper publicity released about the mobile social service clinic; others were stimulated by contacts with the social service staff members at meetings where they had discussed the Migrant Health Program.

In Southern New Jersey the Woodstown office and the mobile clinic have become symbols of a resource belonging to the rural area and have contributed to the awakening attention and interest of the area and the local citizens. The services also appear to be more accessible, and real -- not just a remote -- state, gesture, indifferent and bureacratic.

Like creeping paralysis, there seems to be a slow, healthy re-awakening on the part of responsible citizens, professionals and laymen to the fact that where "there is so much smoke - there must be a fire". The publicity generated by the President's poverty program is now a definite stimulant, which will step-up the interest and reactivate the American humanitarian concern.

There is no doubt but that this is a thrilling moment in history. It is wonderful to be a part of it. Hopefully each effort carefully planned and executed with regard to fundamental and constructive practice; well coordinated with the total "push"; directed and manned by adequately equipped personnel will make a dent in our "House of Shame" during this generation.

HEALTH EDUCATION

> "Successful introduction of change depends on extensive knowledge of the culture and the needs of the people." Community discussion groups invariably comment, "This has been very interesting, we have seen the workers as we drive along the road but we never thought of them in this way."

Recognizing health education as the keystone to lasting gains in migrant health, the State Department of Health this year secured the services of a health educator experienced in community health organization among low income, unskilled-worker groups without much formal education. The health education staff was further enriched by the temporary assignment of a Puerto Rican health educator by arrangement with the University of Puerto Rico's School of Tropical Medicine, and a health education COSTEP student assigned by the United States Public Health Service, and another undergraduate student.

The philosophy behind the migrant health education program was well stated by a nutrition consultant early in the year. Although she spoke of food, her comments held equally true for every phase of migrant education: "We must have respect for food habits and build on them," she said. "Food nourishes not only the body but also many of man's deepest sentiments - his religious feeling, his cultural identification, his need for sociability. Set realistic goals. Make experience hopeful instead of despairing. Most migrants have only despair in their lives. Even a slight change for the better in human behavior is a huge accomplishment."

It was with this respect for the migrants' engagement with life, their problems, the inner society of their camps, their understanding, aspirations and innate ability that the health educators tackled the job of exploring and overcoming the migrants' lack of knowledge and lack of motivation.

On August 28, interviewing of migrant workers began for a special survey questionnaire devised by the health education staff to probe the migrants' attitudes towards themselves, their work, their health problems and practices and their knowledge and use of available community health services. With permission of the farmers, interviewing was arranged for after work hours in the camps. By the end of September, 81 questionnairs were completed, 19 in English and 62 in Spanish. The 19 English-speaking Southern Negroes came from Georgia, Florida, North Carolina, Alabama, Mississippi, Arkansas and Louisiana. Two-thirds of the group were over 25 years of age. The group averaged 5.5 grade years of school per person.

Of the 81 people interviewed, 49 had entered the migrant stream because of failure to find other work or the need to make more money, three-fourths indicated a preference for working and living in the same place all year round, 71 per cent did not want to see their children do migrant agricultural work. They indicated that the reasons were the hard work, the low pay, and the statements "they suffer," and "they get old". They wanted their children to be educated for better jobs.

Fifty per cent of the workers expressed dissatisfaction with the housing situation, and many with the pay. If given an opportunity to work in another occupation, 89% would choose another, and 62% of these would choose factory work. Answers on out of camp activities indicate that the migrants spend a substantial amount of their earnings in New Jersey communities.

Answers concerning health information and practices indicated that migrant workers do not recognize which signs of illness point to the need for medical care.

Between 35 and 67 migrants failed to answer questions concerning symptoms and signs indicative of personal illness, or illness in members of their family.

Forty-one of the 72 workers indicated what they would do if specific symptoms or signs of illness occurred. They indicated that they didn't work when they had symptoms, but frequently remarked that their answer depended upon "how bad it was". If the symptoms were slight they would go to work, if they became severe, they did not work. Only 7 persons mentioned a doctor as a resource.

Sixty workers indicated knowledge of one symptom o sign indicative of tuberculosis. Cough seemed to be the most commonly recognized symptom. Only 2 persons mentioned the chest X-ray. Fifty-two persons said that they did not know the signs of appendicitis. Sixty-two persons said they did not know the signs or symptoms of syphilis. In general the migrants interviewed could not answer questions dealing with illnesses which are frequently found in migrant camps. While the migrant appears to act in the presence of certain diseases, nevertheless, it is clear that he does not recognize the symptoms of these diseases. When illness occurs he does not recognize the specific symptoms of disease but rather acts because he "feels bad" and seeks assistance if the illness is "bad enough".

Although 78 mentioned handwashing before meals and after toilet as helpful to keep well, it was difficult to see how they could accomplish this since camp inspections reveal that handwashing facilities are not available in the field.

The workers showed little knowledge about protection against disease through immunization.

Although 38 workers claimed that they get a regular health examination when they feel well, this observation is subject to question on the basis of practical experience in the camp.

The survey results, of which the above details represent only highlights, will help guide future health education plans for the entire migrant health staff. As significant as the specific answers may be, equally important is the direct knowledge of migrant living conditions gained by the staff through on-the-spot campsite interviewing, and the many direct contacts established between the migrant workers, farmers, crewleaders, and the health educators in the course of collecting information.

To help build attendance at six clinics held in four locations, the health educators sent letters to the farm owners. They provided Spanish-English material for professional workers, posters, and press releases. They communicated with about 1000 farmers concerning the services available at the Woodstown office. The Puerto Rican Health Educator prepared press releases in Spanish for the Spanish language press on the mainland and Puerto Rico. They administered simple literacy tests at several clinics in Spanish and at all clinics in English. About 1/3 of those from Puerto Rico were found to be illiterate in Spanish. Of the English-speaking people, those under about 40 years of age were able to read simple pamphlets.

To observe the potential of crewleaders to help serve as a bridge between the Health Department and the migrant workers, a health education meeting was arranged with crew leaders from Salem and Gloucester Counties. At this meeting,which was the first time that the Health Department had met with crew leaders, U.S.P.H.S. films were shown on camp sanitation, food sanitation and personal cleanliness, followed by discussion. The session was so successful that there was a request for a showing of these films to the workers at the camp-sites. One program took place before the end of the summer. Another crew leader's meeting was held by the Cumberland County Health Department at the Rosenhayn Firehouse. A pocket-size directory was prepared for distribution to crew leaders at these meetings, containing information on health and welfare resources for migrant workers in the area. It also offered Spanish interpreter service if necessary for workers in difficulty with the law.

Preceeding the two clinics scheduled for August 17 and 19 at the Jill and Kelly farms, the health educators contacted 40 farm owners by telephone for permission to visit and talk to workers, and spent 12 days (and nights) visiting 24 farms at least once and speaking directly to more than 230 workers. Workers were informed of immunization services and invited to a film and speaker program to be held the night before the August 17 clinic. Crew leader contacts paid off as each of these men, too, spread the word among their workers about the importance of immunization. The manager of the Cow Town auction donated a booth, at which health educators talked to workers and distributed printed materials about the clinics and the services available through the Migrant Health Office in Woodstown. The effectiveness of these activities was seconded by the steady arrival of new workers in the area for the tomato harvest.

On Sunday, August 16, at the Jill Brothers main farm, more than 130 workers attended the publicized session to see a film in which the English sound track was replaced by a tape-recorded Spanish translation. The interest shown in the film and in the discussion session that followed was translated into action on Monday night, August 17, when the large clinic attendance at the farm included more than 100 new persons. On August 19, more than one-half of the migrants at the Kelly Brothers farm clinic were first-timers. The transportation problem was overcome by the car pool organized by the educators. Recorded American and Puerto Rican music kept the clinic atmosphere informal and relaxed. The health educators spoke to migratory workers as they stood in line at the clinics.

Clinic interest was reinforced by a demonstration of the use of dry milk, with on-the-spot tasting and the distribution of 134 quart samples. The choice of dry skim milk for this nutrition education project was because many camps do not have refrigeration and the increased use of the milk would provide needed protein. Besides demonstrating that the cost of food is not necessarily an indication of its nutritive value, the milk demonstration established good direct communication because of the participation of Spanish-speaking personnel, who asked leading questions about the migrants' problems in nutrition and food purchasing.

The particular interest shown in this demonstration by the men, who encouraged their wives to accept the samples, underlined the central role played by the husband in Puerto Rican families. Health education efforts should be focused on the male in these groups to assure success.

With the help of the health education staff, teachers working in the Glassboro State Teachers College Program at a Rosenhayn camp presented a program on veneral disease at the camp, a subject in which the migrants at this camp had expressed special interest. At the conclusion of this program, one of the migrant workers present brought a case of secondary stage syphilis directly to the attention of the venereal disease investigator who had participated in this session.

Films, pamphlets, posters, flip charts and other visual aide material were inadequate in both content and availability. This is true of both English and Spanish material.

In evaluating available health education material, the health educators judged much of it to be ineffective because of its failure to take into account the variety of cultures from which the migrants stem. They may be Southern Negro, Puerto Rican, British West Indian, or urban white. Any migrant group may be as heterogeneous as any other occupational group. In approach and levels of literacy, written materials must be as identified with the cultures of the people they are intended to serve not just the languages of the migrant.

The study of migrant attitudes toward health is included as appendix.

SANITATION AND ACCIDENT PREVENTION

> "The dismaying thing is that what you see represents a substantial improvement over the condition a few years ago. Yet there were many tidy camps, and people doing the best they could in small, inadequate quarters."

All 2,050 migrant labor camps widely dispersed through the state's 21 counties were visited this year by the inspection staff of the Migrant Labor Bureau (State Department of Labor and Industry), augmented by two assistant sanitarians supplied by the State Department of Health.

A six-week training course in environmental sanitation was held early this year for inspectors, with technical specialists from the State Department of Health cooperating as lecturers. The course included a description of sanitation related sewage disposal, water supplies, housing, food preparation, and the elements of personal hygiene, to help arm camp inspectors with the scientific knowledge and understanding needed to do their job thoroughly and to help them explain their decisions better to farmers.

Of an estimated 7,437 camp inspection visits, 2,247 were approvals, 3,767 were conditional approvals, and 1,023 were disapprovals. Upon final inspections, all those in violation had been corrected except 37 whose operations were brought to hearing by the Department of Labor and Industry, and were assessed penalties under the law.

Of the 13,291 defects reported, 2,727 were toilet and privy violations, 1,590 were violations concerning water and washing facilities, 538 were violations involving garbage disposal, and 275 were food preparation violations. Less than 15% of all camps were observed to have flush toilets, a figure paralleling the observations recorded by the public health nurses on their special camp visitation forms, according to which flush toilets were noted in 58 of 363 camps.

Many farmers apparently thought that the piping of waste bathing, laundry and dishwater to the back of buildings was permissible, just as long as raw sewage was not running on the ground surface. It was necessary to impress on them that these were serious drainage violations because stagnant pools of waste-water are ideal breeding places for mosquitoes.

Many farmers showed notable interest and cooperation in the elimination of violations and in improving living conditions, with the feeling that better housing attracts better workers. During the last three years, 150 new camps or replacements have been built with adequate showers, washrooms and other facilities, including piped hot and cold water and new toilets. The camps in North Jersey were estimated to be better in construction and maintenance than others because they house fewer occupants, with a consequent lesser risk of damage. Moreover, most Northern New Jersey migrant camps are within city limits and must meet city regulations.

Despite progress, however, bad pockets of housing with many health and safety hazards still remain. Many growers resist making improvements because they clain that camp occupants abuse the facilities. Both the field sanitarians and the public health nurses agreed that migrants do not accept sufficient responsibility for sanitation. Much intestinal distress that migrants accept as inevitable can be traced to parasites that thrive on the poor habits of the migrants themselves. In camps where women do the cooking and live on the premises, better conditions exist than where the men are their own cooks.

Although farmers usually make the essentials available, the migrants need a tremendous amount of education in personal hygiene, sanitation and cleanliness. The Bureau of Migrant Labor took a step in this direction by sending out a Spanish-speaking inspector for a period of six months, with the special assignment of instructing camp occupants in the care of facilities and in the basic rules of sanitation and personal cleanliness, with special attention to use of privies and maintenance of kitchens. A total of 763 visits were made for this purpose.

With increased knowledge of what constitutes pure water supplies as a result of the course in environmental sanitation, the two camp sanitarians employed by the Department of Health were able to conduct a water-sampling program as a routine part of inspection. Most farmers were extremely interested in water-sampling, particularly since they often use the same water supply as their men. Where water samples proved contaminated, camp operators received information on how to correct this condition.

Between May and September, 148 water samples from camps in Gloucester and Salem counties were forwarded to the State Laboratory at Trenton. Testing revealed that 26 of these camps, or 21%, were using water contaminated by fecal organisms. In each case, the camp operator was notified and advised to take corrective measures and to disinfect the well for reinspection. Fifteen wells were re-tested one or more times. Eight wells received a favorable report upon re-tests following corrective measures. Because of lack of personnel, 11 wells were not re-tested. At the end of the summer, 18 wells remained not certified as safe on the strength of laboratory evidence, although some of these were no longer in use.

This year's water-sampling project was only a start at best. Water-sampling must compete with a multiplicity of other housing and sanitary conditions for attention, since each inspector is responsible for reporting on 52 different items on each visit. In Gloucester County alone, where most of the water-sampling was done, one inspector was responsible for visiting about 500 camps housing approximately 4,000 workers. Since a significant percentage of those camps tested in Gloucester were found to be using contaminated water, it is probable that many untested camp water supplies in the area are also polluted, as may also be true for migrant camps in other counties. Obviously, extension to all camps would require a larger staff, and more training for inspectors not sufficiently experienced in this activity.

Both migrants and farmers must share responsibility for controlling the numerous safety hazards that exist in many camps if a constructive approach is to be made to child protection and general accident prevention. As a move towards planning for migrant worker safety, the Accident Prevention Program sought data on migrant accidents in New Jersey, with the assistance of the Glassboro Service Association, which made available medical and compensation case records. A monthly tabulation of migrant accidents by type and age was compiled, to guide future safety education. In addition, an accident questionnaire for migrants was devised and a series of slides was made graphically demonstrating conditions in migrant camps to familiarize nurses, inspectors and others with unsafe conditions and practices.

Accident rates by month and age groups are unknown because of insufficient population data.

Comparing the data of both years for the period April through September, there were 189 accidents in 1964 and 172 in 1963 and 18 non-accidental skin conditions in 1964 and 10 in 1963.

Both the 1963 and 1964 data indicate that the categories of accidents listed: sprains and strains, falls, knives, tools, equipment and machinery and foreign body entering eye, are the accidents of greatest incidence. Both sets of data also indicate that most of the accidents by incidence per month occure in the months of May through August. This is also true of sprains and strains, and for falls and loss of balance (except that September is a high month for falls too) and foreign body entering eye. Knife and tool injuries were most prominent in May and equipment and machinery injuries in July. The frequency of non-accidental skin conditions was greatest in July.

EVALUATION

This is the second year in which a major effort has been mounted to increase, extend and improve health services for migrant agricultural workers in New Jersey. Building upon the experiences of 1963 an effort was made to increase nursing service in the Spring. In the Southern Counties the Cumberland County Health Coordinator's office resumed responsibility and in the Salem, Gloucester area a nurse employed by the Department resumed service beginning on April 1, 1964. This service, though limited in scope, was useful and established a base for continuity of action throughout the Summer.

The contracts for services of county medical directors were renewed and the physicians were involved in service at an earlier point in the season than in any previous year. Contracts for individual physician services were completed prior to July 1st and served a most important part in obtaining more community physician involvement.

Medical Social services were available to workers from April 1st throughout the Season with increasing staff and skill as the season progressed.

The program of health services went into high gear on June 29, 1964 with an orientation conference including all agencies and disciplines who were involved in direct services. The experiences of the previous year were described. The field trial experiences of the Spring were explained and efforts to establish useful data collection devices and lines of communication were undertaken. The nursing field staffs of contract agencies and the Department were all seasoned workers of the previous year.

Each agency in its own way carried out an improved and expanded program. In the multitude of occurrences and reports of 8 weeks of high pressure there are many points which become obscure with time, and which are lost in reports. Fine details of the past summer's work will not be described. The major points must be given emphasis.

Never before in the history of the Migrant Health Program has it been possible to say that 453 camps were served one or more times; that over 5,000 persons in these camps had one or more opportunities to communicate with the nurse or other health worker who visited the camp; that direct visits were made to over 1,300 persons for many reasons, principally tuberculin screening and health counselling; that the number of persons seen in camps nearly equals the number of persons who were seen in clinics in previous years. We are aware also that many migrants were seen more than once, and that for those where the need was intense, the frequency of visitations was proportioned to the need.

Not only were the patients seen, but household members were observed. Thus it can be said that health services and observations were extended to the workers and their families within the camp and within the walls of their housing units.

Increasing numbers of persons, over 2,500, were observed in the migrant health clinics, through a variety of clinic services. Trials of services beyond basic screening programs and immunization activities were conducted in nutrition, in dentistry and in health education. These programs, in relation to the clinics, added a new dimension. The concept of a fixed clinic readily acceptable to the migrant area is receiving more attention and may be used soon on a trial basis to meet the cultural needs of a large proportion of migrants. This clinic will meet weekly in a central location in an attempt to duplicate the relationships existing in Puerto Rico.

The active participation of hospitals in Migrant Health activity was continued and expanded, with a more defined relationship established in the provision of out-patient and laboratory services. A deficit in funds for in-patient care is a major problem. Current hospital bills total over $47,000 and only $9,000 from State sources are available for payment. Some very pointed efforts to win support of municipal welfare boards in meeting hospital costs were almost entirely fruitless.

Progress was made in the field of medical social services in developing more effective channels of communication between the migrant in need and the professional worker serving in agencies and in the project. Much remains to be done in this area since cases continue to come to light who have been in need for days, weeks, and months. There remain several areas of differing attitudes. One is that social service is used only as a last resort. This is true particularly when it is time to discharge patients who have been hospitalized for several weeks or months, or there is need to transfer a patient to another jurisdiction. Another conflicting viewpoint exists over the policy of short-term casework versus long-term preventive counseling. The reality of the first is forced upon us by the nature of migrancy and the emergent needs of the workers. For many, survival needs must be met. In addition there is need to help the migrant to be as self sufficient as possible within his own and conflicting cultures. Extensive counseling of those with long-term problems limits the time available to explore and assist with the more pressing needs of the many, which if unattended, only lead to more serious future difficulties. The choice between these different approaches will be made only in the area of experience. This question will be resolved against the backdrop of a population in misery, whose needs are easily overlooked and rejected, and who do not know their rights, nor resources available, and who do not have the savvy to use them.

The introduction of a health education staff in the Project this year occurred with stunning speed. One day there was no staff, the next day almost too many. The responses of the persons who came together suddenly and who were thrust into a struggle with which they were not familiar, is most praiseworthy. The attitude study, conceived and executed in 2 1/2 months, amplifies in substantial manner the understanding of the migrant as a human being not different from the rest of us except by environment. His frustrations, aspirations and reactions to society around him need to be studied more. For if he is understood without prejudice, without fear and without rejection, there is no doubt that his contributions will be more readily appreciated.

Sanitation services continue to be a great need. The observations related to contaminated water supplies indicate the path for future action.

Not everything in this project was golden and successful. With increasing involvement of professional disciplines and staff, there are inevitable stresses that emerge in communications, in planning, in interdisciplinary approaches to problems, in perception of the project, and in relationship to the problems and persons served. If these differences did not exist, the professionals involved would not be doing their job. From these differences flow the opportunities for new ideas, for better function and for improvement in its second major year. It is concluded that the drive and momentum of this project is increasing; that there is also an attitude and willingness to challenge existing structure of health and welfare services; and finally, a more experienced staff will meet the next season in a more highly refined state of readiness.

RECOMMENDATIONS

1. More planning sessions be provided early enough in the year to allow agency staffs and associated personnel to plan intelligently and harmoniously with the Migrant Program.

2. Orientation of all employees be more intensive involving two days. Individual disciplines should work alone for one day, on the second day a general meeting should be held which would include a broad discussion of the cultural characteristics of migrants.

3. Interviewing techniques be included in staff orientation and in-service sessions. If personnel placed more emphasis on encouraging migrants to engage in conversation and took the time to display interest and listen to what the worker had to say, they could learn more about the culture and attitudes of the individual involved.

4. Brief Spanish lessons provided each day for the staff.

5. Additional clerical staff be obtained for the project.

6. The field office in Woodstown, New Jersey be continued.

7. The information contained in the annual report should be presented to the staff of the Labor Office of the Commonwealth of Puerto Rico, the two Farm Labor Associations and to Farm Groups in general for their evaluation and reaction.

8. Other screening tests be included in the clinic sessions. Diabetes Screening seems to be the most likely, this may be undertaken in selected clinics if resources for follow-up are adequate.

9. The Rapid Plasma Reagin Card Test be extended to all field clinic operations, with VDRL to be done only on positives.

10. Special hours for x-ray of tuberculin reactors be established at hospital clinics and other facilities and emphasis placed on organization of facilities for transportation.

11. Mobile chest x-ray units be used at large clinics, and consideration be given to establishing fixed installations where feasible and where no other facilities exist.

12. A mobile dental unit be available to help migrants with dental needs.

13. An assistant Public Health Nurse Supervisor be employed to assist in the nursing supervision of the nursing program in the migrant schools and to participate in planning conferences, direct services to patients, clinic service and emergency medical care.

14. The services of a Puerto Rican nurse be secured to eliminate the need for a full time interpreter.

15. An exchange of Public Health Nurses with Puerto Rico be explored.

16. Farmers, crew leaders, when feasible, and others be included in planning for clinics next season.

17. Planning be undertaken in the winter, specifically in Southern New Jersey before April first.

18. Clinic dates and locations be published to all personnel, sanitarians, school personnel, etc., they too can publicize the clinic.

19. Farmers be made a part of the overall community immunization program. The Farm Bureau Association and Glassboro Association be approached to participate in the immunization program.

20. A more equitable method of payment for hospital services be developed to replace the present system of prorated payment now in effect.

21. Contracts with physicians for out-patient care be offered in other counties wherever the need exists.

22. Better and closer communications be established between the Eastern Seaboard States employing migrant workers. Reinforce the various programs of the States.

23. The Migrant Health Branch, U.S. Public Health Service develop and provide a directory of key agencies within the various States whereby the worker could receive aid or be given a referral to the agency best equipped to handle the problem.

24. The medical social worker, Puerto Rican, continue on an annual basis.

25. An additional medical social worker be employed to provide medical social services for hospitals for migrant workers in Burlington, Middlesex, Mercer and Monmouth Counties.

26. Health Education activities be conducted with small groups held at the camp site where feasible. This will require the participation of the migrants, and contact with many farmers and crew leaders.

27. Spanish language radio broadcasts be used for short announcements to the Puerto Rican Migrants.

28. There be continuing review and evaluation of the English and Spanish Health Education and information material to assure that it is identified with the culture of the persons and the resources available.

29. The Health Educator, Puerto Rican, participate in the project in New Jersey on an annual basis.

30. **Water sampling activity be extended to the largest number of counties that available manpower will permit.**

31. **Education of migrants in environmental sanitation be amplified through the inspection staff of the Bureau of Migrant Labor.**

Appendix I

NUMBER OF PERSONS SERVED IN MIGRANT HEALTH CLINICS BY PROFESSIONALS
MIGRANT HEALTH PROGRAM
NEW JERSEY 1964

COUNTY	Number Clinic Sessions	Number of Persons Served By			
		Total	Nurse Only	Physician & Nurse	No Data
TOTAL	71	2375	1505	783	87
Atlantic	10	108	108		
Burlington	18	392	314	78	
Camden	2	15	15		
Cumberland	18	829	447	382	
Gloucester	8	161	89	3	69
Mercer	1	63	54	9	
Middlesex	3	278		278	
Salem	11	529	478	33	18

CONDITIONS OR PROBLEMS OBSERVED IN MIGRANT HEALTH CLINICS
BY AGE AND SEX
MIGRANT HEALTH PROGRAM
NEW JERSEY 1964

CONDITION OR PROBLEM	TOTAL	SEX AND AGE GROUPS							
		Under 15		15-44		45+		Unk.	
		M	F	M	F	M	F	M	F
Prenatal	14				14				
Post Partum	2				2				
Poisoning									
Gyn									
VD	39			25	7	2	5		
Eye	7			6		1			
Crippled Child.	1		1						
Mental Retard.	2	1	1						
Mental Health									
Dental	37		4	23	7	1	2		
Worms	8	3	5						
Cardiac									
Injury	9	1	2	5			1		
Cancer									
Tuberculosis	107	2	2	67	12	20	3	1	
Counseling	91	12	10	36	16	12	5		
Diabetes	2				2				
Hypothyroidism	1						1		
Umbilical Hernia	1	1							
Other Medical	9		3	3	2		1		
Other	12	5	1	3	1	2			

NUMBER OF PERSONS RECEIVING SPECIFIED SERVICES BY SEX AND AGE IN MIGRANT HEALTH CLINICS
MIGRANT HEALTH PROGRAM
NEW JERSEY 1964

SERVICE	TOTAL	SEX & AGE GROUPS							
		Under 15		15-44		45+		Unk.	
		M	F	M	F	M	F	M	F
DPT	373	148	201	5	5	1	1	163	3
DT	1624	68	43	875	298	254	67	15	4
Polio	1794	178	203	836	264	240	65	5	3
Smallpox	15	4	11						
Tuberculin Adm.	1714	227	227	701	295	174	68	20	2
Tuberculin Read	1465	180	232	563	254	170	50	15	1
X-Ray Chest	24			12	4	6	2		
*STS	1632		41		1172		419		
Physical Inspection	334	31	45	143	58	45	12		
RX G.C.	1			1					
RX Syphilis	55	1		21	15	13	5		
Treatment	22	4	7	6	3	1	1		
Literacy test	16		5	9		1	1		

* Figure includes both male and female

Appendix II

DISTRIBUTION OF MIGRANT AGRICULTURAL WORKERS RECEIVING INDIVIDUAL SERVICE, BY COUNTY AND SEX NEW JERSEY 1964

County	Total	Number Persons		Percent
		Male	Female	Male
All	1,833	1,119	714	61.0
Atlantic	13	1	12	7.6
Burlington	207	135	72	65.2
Camden	3	2	1	66.0
Cumberland	183	113	70	61.7
Gloucester	196	100	96	51.0
Mercer	64	35	29	54.7
Middlesex	67	24	43	35.8
Monmouth	832	583	249	70.0
Salem	268	126	142	47.0

DISTRIBUTION OF MIGRANT AGRICULTURAL WORKERS RECEIVING INDIVIDUAL SERVICES BY COUNTY AND AGE NEW JERSEY 1964

County	Total	Number of Persons				Percent over 15 years
		0-14	15-40	45+	Unk.	
All	1,833	581	819	363	70	63.4
Atlantic	13	5	6		2	46.0
Burlington	207	60	100	36	11	65.7
Camden	3		2		1	66.0
Cumberland	183	50	73	50	10	67.2
Gloucester	196	98	66	9	23	38.3
Mercer	64	17	22	23	2	69.2
Middlesex	67	39	26	2		41.8
Monmouth	832	183	431	209	9	76.9
Salem	268	129	93	34	12	47.4

DISTRIBUTION OF MIGRANT AGRICULTURAL WORKERS RECEIVING INDIVIDUAL SERVICE BY PROFESSIONAL RENDERING SERVICE AND COUNTY
NEW JERSEY 1964

		Number of Persons		
County	Total	Nurse	Health Educator	Social Worker
All	1,833	1,819	37	14
Atlantic	13	13		
Burlington	207	207		
Camden	3	3		
Cumberland	183	179	14	10
Gloucester	196	187	9	2
Mercer	64	64		
Middlesex	67	67		
Monmouth	832	832		
Salem	268	268	14	2

DISTRIBUTION OF MIGRANT AGRICULTURAL WORKERS RECEIVING INDIVIDUAL SERVICE BY PURPOSE OF SERVICE AND COUNTY NEW JERSEY 1964

PURPOSE OF SERVICE	Number of Persons									
		County								
	Total	Atl.	Burl.	Cam.	Cumb.	Glou.	Mer.	Mid.	Mon.	Salem
All	1833	13	207	3	183	196	64	67	832	268
Prenatal	46	1	5		7	5		10		18
Post Partum	29	4			11	4		4	1	5
Poisoning	1					1				
Gyn	3		1					1		1
VD	5		3			1		1		
Eye	11				4					7
Crippled Child	4				2	1				1
Mental Retard.	7				2	4				1
Mental Health	1				1					
Dental	8				3			3		2
Worms	22				6			13		3
Cardiac	4		1		1	1		1		
Injury	36			1	11	5	1	12	3	3
Cancer	3		1							2
Tuberculosis	74		59		5					10
Acute CD	74		52		3	5		2		12
Counseling	400		28		13	156	60	13	7	123
Diabetes	5		1		4					
Social Serv.	2				1	1				
TB Screen.	879				49				813	17
Misc.	219	8	56	2	60	12	3	7	8	63

DISTRIBUTION OF MIGRANT AGRICULTURAL WORKERS RECEIVING INDIVIDUAL SERVICE BY TYPE OF NEED AND BY COUNTY
NEW JERSEY 1964

County	Number Persons				
	Total	Type of Need			
		Out-pt.	In-pt.	Physician	Other
All	1,833	290	13	77	1,453
Atlantic	13	1			12
Burlington	207	37	1	1	168
Camden	3				3
Cumberland	183	9	5	38	131
Gloucester	196	14	4	13	165
Mercer	64	1			63
Middlesex	67	38	1	4	24
Monmouth	832	149			683
Salem	268	41	2	21	204

DISTRIBUTION OF MIGRANT AGRICULTURAL WORKERS RECEIVING INDIVIDUAL SERVICES BY PURPOSE OF SERVICE AND BY ACTION TAKEN ON THEIR BEHALF
NEW JERSEY 1964

Purpose of Visits	Total	Referral	Health Education	Immun.	Case Work	Nursing Care	Other
Total	1,833	641	326	122	8	33	703
Prenatal	46	34	6			1	5
Post Partum	29	3	19			2	5
Poisoning	1	1					
Gyn	3	1	1				1
VD	5	1	4				
Eye	11	8	2		1		
Crippled Child.	4	1	2				1
Mental Retard.	7	5			1		1
Mental Health	1	1					
Dental	8	8					
Worms	22	12	1			2	7
Cardiac	4	3	1				
Injury	36	21	1		1	3	10
Cancer	3	2					1
Tuberculosis	74	34					40
Acute CD	74	6	3	49		13	3
Counseling	400	105	232	13	2	2	46
Diabetes	5	1	2				2
Social Serv.	2				2		
TB Screen.	879	340		6			533
Misc.	219	54	52	54	1	10	48

DISTRIBUTION OF MIGRANT AGRICULTURAL WORKERS RECEIVING INDIVIDUAL SERVICES BY AGENCY TO WHICH REFERRED AND COUNTY
NEW JERSEY 1964

		Number of Persons			
		Referred to			
County	Total	Hospital	Public Welfare	Social Service	Other
All	641	279		5	357
Atlantic	1	1			
Burlington	24	12			12
Camden	0				
Cumberland	111	58		1	52
Gloucester	43	10		2	31
Mercer	3	1			2
Middlesex	50	27		2	21
Monmouth	290	149			141
Salem	119	21			98

DISTRIBUTION OF MIGRANT AGRICULTURAL WORKERS RECEIVING INDIVIDUAL SERVICES BY FREQUENCY OF SERVICE AND COUNTY
NEW JERSEY 1964

	Number of Persons							Percent 3 or more Visits
		Frequency of Visits						
County	Total	1	2	3	4	5	6 or more	
All	1,833	749	884	111	54	21	14	10.9
Atlantic	13	12	1					
Burlington	207	89	84	11	21	1	1	11.1
Camden	3	3						
Cumberland	183	145	19	9	5	4	1	10.4
Gloucester	196	114	58	10	6	4	4	12.2
Mercer	64	34	29	1				
Middlesex	67	19	25	14	3	2	4	34.3
Monmouth	832	139	619	56	10	6	2	8.8
Salem	268	194	49	10	9	4	2	12.9

DISTRIBUTION OF VISITS TO MIGRANT AGRICULTURAL WORKERS BY FREQUENCY OF VISITS AND COUNTY NEW JERSEY 1964

COUNTY	Number of Person Visits				Percent of Total Person Visits Due to 3 or More Visits Per Patient
	Total	Frequency of Visits			
		1	2	3 or more	
All	3278	749	1768	761	23.2
Atlantic	14	12	2		
Burlington	387	89	168	130	33.6
Camden	3	3			
Cumberland	261	145	38	78	30.0
Gloucester	334	114	116	104	31.1
Mercer	95	34	58	3	3.2
Middlesex	157	19	50	88	56.0
Monmouth	1637	139	1238	260	15.9
Salem	390	194	98	98	25.1

DISTRIBUTION OF PERSON VISITS TO MIGRANT AGRICULTURAL WORKERS BY TYPE OF SERVICE RENDERED BY COUNTY NEW JERSEY 1964

COUNTY	Number of Person Visits				
	Total	Health Education	Nursing Care	Referrals	Other
All	3278	521	1401	728	610
Atlantic	14	2	3	1	8
Burlington	387	21		28	338
Camden	3			3	
Cumberland	261	50	11	88	112
Gloucester	334	199	12	97	26
Mercer	95	78		3	14
Middlesex	157	34	10	97	16
Monmouth	1637	32	1331	273	1
Salem	390	105	34	138	95

DISTRIBUTION OF MIGRANT AGRICULTURAL WORKERS RECEIVING INDIVIDUAL SERVICES, FOUND TO HAVE SOCIAL NEEDS BY TYPE OF SOCIAL NEED AND COUNTY
NEW JERSEY 1964

County	Number of Persons				
		Type Need			
	Total	Case Work	Financial Aid	Employment Aid	Other
All	50	15	28		7
Atlantic					
Burlington					
Camden					
Cumberland	25	6	16		3
Gloucester	9	2	4		3
Mercer	1				1
Middlesex	6	3	3		
Monmouth					
Salem	9	4	5		

DISTRIBUTING OF MIGRANT AGRICULTURAL WORKERS RECEIVING INDIVIDUAL SERVICES, AND WITH SOCIAL NEEDS BY REFERRAL ACTION AND COUNTY
NEW JERSEY 1964

County	Number of Persons				
		Referred to			
	Total	Hospital	Public Welfare	Social Service	Other
All	50	11		10	29
Atlantic					
Burlington					
Camden					
Cumberland	25	6		7	12
Gloucester	9	3		1	5
Mercer	1			1	
Middlesex	6	1		1	4
Monmouth					
Salem	9	1			8

DISTRIBUTION OF MIGRANT AGRICULTURAL WORKERS RECEIVING INDIVIDUAL SERVICE, HAVING PUBLIC HEALTH SERVICE HEALTH RECORD BY COUNTY
NEW JERSEY 1964

COUNTY	NUMBER OF PERSONS				PERCENT	
	Total	Having PHS Record		Given PHS Record	Having	Given
		Yes	No			
All	1833	270	1563	864	14.7	47.1
Atlantic	13	3	10	8	23.0	61.0
Burlington	207	17	190	89	8.2	42.5
Camden	3	1	2	2	33.3	66.6
Cumberland	183	6	177		3.2	
Gloucester	196	44	152	24	22.4	12.2
Mercer	64		64		0.0	
Middlesex	67	33	34	3	50.0	4.5
Monmouth	832	82	750	684	9.8	82.2
Salem	268	84	184	54	31.3	21.1

DISTRIBUTION OF MIGRANT AGRICULTURAL WORKERS OVER 15 YEARS OF AGE HAVING SOCIAL SECURITY CARDS BY COUNTY
NEW JERSEY 1964

COUNTY		Number of Persons Having Social Security Card			Percent Having	
	Total	Total	Male	Female	Total	Males
All	1252	767	523	244	61.0	68.0
Atlantic	8	4	2	2	50.0	50.0
Burlington	147	97	20	77	66.0	20.3
Camden	3				0.0	
Cumberland	133	67	55	12	50.0	82.5
Gloucester	98	45	22	23	46.0	50.0
Mercer	47	2	2		4.2	100.0
Middlesex	28	8	3	5	28.4	37.5
Monmouth	649	470	387	83	72.5	82.0
Salem	139	74	32	42	53.0	43.0

Appendix III

NUMBERS OF MIGRANTS AND DEPENDENTS RECEIVING SPECIFIED SERVICES IN RELATIONSHIP TO GENERAL MEDICAL CARE

NEW JERSEY 1964

CONDITION	NUMBER OF PERSONS				
	GENERAL MEDICAL CARE				
	Total	Only	Plus Social Service	Plus Nursing	Plus Nursing & Social Service
TOTALS	442	71	18	335	18
Eye Condition	7	2	1	2	2
Cancer	3			3	
Malnutrition	2	2			
Poisoning	5	1		4	
Congenital Defects	4	2		1	1
Mental Illness	1	1			
OB and GYN	68	1	5	61	1
Arthritis	2			1	1
Alcholism	2			1	1
Kidney Infection	17	2	2	10	3
Abdominal Condition	14	3	1	10	
Virol Infection	5			5	
Cardiac	11	1	2	8	
External Infection	1			1	
Anemia	1			1	
Dental	2			2	
Hernia	6	2		4	
Diabetes	3	1		2	
Laceration	95	3	4	82	6
VD	4	3		1	
Central Cerebral System	11	2		8	1
Contusion	10	2	1	7	
X-rays	110	32	1	75	2
U.R.D.	31	7		24	
Social Services	1		1		
No diagnosis	26	4		22	

NUMBERS OF MIGRANTS AND DEPENDENTS RECEIVING SPECIFIED SERVICES IN RELATIONSHIP TO EMERGENCY TREATMENT

NEW JERSEY 1964

CONDITION	NUMBER OF PERSONS				
	EMERGENCY TREATMENT				
	TOTAL	Only	Plus Social Service	Plus Nursing	Plus Nursing & Social Service
TOTALS	65	8	0	53	4
Kidney Infection	2	1		1	
Abdominal Cond.	4			4	
Virol Infection	3			1	2
Diabetes	1	1			
Laceration	25	6		19	
VD	1			1	
X-rays	3			3	
U.R.D.	5			3	2
No diagnosis	21			21	

NUMBERS OF MIGRANTS AND DEPENDENTS RECEIVING SPECIFIED SERVICES IN RELATIONSHIP TO OBSTETRICAL CARE

NEW JERSEY 1964

CONDITION	NUMBER OF PERSONS				
	OBSTETRICAL CARE				
	Total	Only	Plus Social Service	Plus Nursing	Plus Nursing & Social Service
Total	38	4		31	3
OB & GYN	37	4		31	2
No diagnosis	1				1

NUMBERS OF MIGRANTS AND DEPENDENTS RECEIVING SPECIFIED SERVICES IN RELATIONSHIP TO SURGICAL CASES

NEW JERSEY 1964

CONDITION	NUMBER OF PERSONS				
	SURGICAL TREATMENT				
	TOTAL	Only	Plus Social Service	Plus Nursing	Plus Nursing & Social Service
TOTAL	31	1		15	15
Kidney Infection	3			1	2
Abdominal Cond.	20	1		8	11
Virol Infection	3			3	
Hernia	4			3	1
U.R.D.	1			1	

NUMBERS OF MIGRANTS AND DEPENDENTS RECEIVING SPECIFIED SERVICES IN RELATIONSHIP TO MENTAL HEALTH AND CRIPPLED CHILDREN

NEW JERSEY 1964

CONDITION	NUMBER OF PERSONS				
	MENTAL HEALTH AND CRIPPLED CHILDREN				
	Total	Only	Plus Social Service	Plus Nursing	Plus Nursing and Social Service
Total	8	1	3	2	2
Congenital Defects	1			1	
Mental Illness	5	1	3		1
Central Cerebral System	1			1	
Laceration	1				1

Appendix IV

SOURCE OF LABOR IN CAMPS VISITED BY PERSONNEL OF MIGRANT HEALTH PROJECT NEW JERSEY 1964

County	NUMBER OF CAMPS						Percent Having Crew Leader Labor
		Source of Labor					
	Total	Walk-In	Day-Haul	Contract	Crew Leader	No Answer	
All	453	212	18	79	117	27	26.0
Atlantic	30	14	4	6	5	1	16.6
Burlington	17	6	3		6	2	35.0
Camden	30	13	7	7		3	0.0
Cumberland	75	43		16	12	4	16.0
Gloucester	79	48	1	19	9	2	11.4
Mercer	9	5			2	2	22.2
Middlesex	49	22	1	7	18	1	36.8
Monmouth	56	7		19	30		53.5
Salem	108	54	2	5	35	12	32.4

TYPES OF HOUSING FACILITIES IN CAMPS VISITED BY PERSONNEL OF MIGRANT HEALTH PROJECT NEW JERSEY 1964

County	NUMBER OF CAMPS						
		Type of Facility					
	Total	Converted House	Dorm & Converted House	Dorm	Dorm & Units	Units	No Answer
All	453	21	6	55	13	268	90
Atlantic	30	3		1		16	10
Burlington	17	2	1	1	2	8	3
Camden	30	2	1			10	17
Cumberland	75			8	3	55	9
Gloucester	79	1	1	11		60	6
Mercer	9					1	8
Middlesex	49	3		10		18	18
Monmouth	56	2	1	16	8	19	10
Salem	108	8	2	8		81	9

TYPES OF SERVICES IN CAMPS VISITED BY PERSONNEL OF MIGRANT HEALTH PROJECT NEW JERSEY 1964

County	Total	NUMBER OF CAMPS							
		Type of Service							
		Electric			Water Supply				
		Yes	No	No. Ans.	Open Well	Hand Pump	Elec. Pump.	City Water	No. Ans.
All	363	358	3	2	34	39	219	3	68
Atlantic	20	20			3	5	12		
Burlington	14	13	1		3	3	8		
Camden	13	12	1		4	4	4	1	
Cumberland	66	65		1	-	3	9		54
Gloucester	73	73			-	6	66	1	
Mercer	1	1			-	-	1		
Middlesex	31	31			1	4	26		
Monmouth	46	44	1	1	12	11	18		5
Salem	99	99			11	3	75	1	9

TYPES OF SERVICES OF CAMPS VISITED BY PERSONNEL OF MIGRANT HEALTH PROJECT NEW JERSEY 1964

County	Number of Camps									
	Total	Type of Service								
		Hot Water			Flush Toilet			Refrigerator		
		Yes	No	No Ans	Yes	No	No Ans	Yes	No	No Ans
All	363	251	38	74	58	240	65	271	14	78
Atlantic	20	19	1		7	13		19		1
Burlington	14	11	2	1	5	9		13		1
Camden	13	13			3	9	1	10	3	
Cumberland	66	9		57	1	9	56	8		58
Gloucester	73	66	7		21	52		70	3	
Mercer	1			1			1			1
Middlesex	31	23	5	3	5	25	1	28	2	1
Monmouth	46	36	6	4	9	34	3	40		6
Salem	99	74	17	8	7	89	3	83	6	10

FREQUENCY OF CAMP VISITS BY PERSONNEL OF MIGRANT HEALTH PROJECT NEW JERSEY 1964

County	NUMBER OF CAMPS									Percent 4 or more visits
	FREQUENCY OF VISITS									
	Total	1	2	3	4	5	6	7	8+	
All	453	234	74	52	25	22	11	7	28	20.4
Atlantic	30	18	4	3	1	3	1			16.6
Burlington	17	6	3	3	2	1	1	1		29.4
Camden	30	23	6	1						
Cumberland	75	43	7	8	4	6	1	1	5	22.2
Gloucester	79	57	12	3	5	1			1	8.8
Mercer	9	2	3	2	1		1			22.2
Middlesex	49	18	8	8	3	2	2	1	7	30.6
Monmouth	56	7	14	12	4	5	4	4	6	41.0
Salem	108	60	17	12	5	4	1		9	17.5

NUMBER OF VISITS TO CAMPS BY PERSONNEL OF MIGRANT HEALTH PROJECT BY FREQUENCY

NEW JERSEY 1964

County	Number Visits to Camps								
	Total	Frequency of Visits							
		1	2	3	4	5	6	7	8+
All	1285	234	138	159	100	110	66	49	319
Atlantic	60	18	8	9	4	15	6		
Burlington	47	6	6	9	8	5	6	7	
Camden	38	23	12	3					
Cumberland	195	43	14	24	16	30	6	7	55
Gloucester	128	57	24	9	20	5			13
Mercer	24	2	6	6	4		6		
Middlesex	173	18	16	27	12	10	12	7	71
Monmouth	229	7	28	36	16	25	24	28	65
Salem	291	60	34	36	20	20	6		115

NUMBER OF "PERSON OBSERVATIONS" MADE IN COURSE OF CAMP VISITS BY PERSONNEL OF MIGRANT HEALTH PROJECT

NEW JERSEY 1964

County	Number Person Observations								
	Frequency								
	Total	1	2	3	4	5	6	7	8+
All	5563	465	708	656	530	544	488	433	1739
Atlantic	141	11	17	22	19	56	16		
Burlington	497	6	35	77	96	9	154	120	
Camden	41	3	25	13					
Cumberland	1406	109	166	73	105	236	32	83	602
Gloucester	222	73	12	57	9				71
Mercer	103	2		26	51		24		
Middlesex	497	36	63	92	32	29	52	13	180
Monmouth	1700	22	224	213	171	151	198	217	504
Salem	956	203	166	83	47	63	12		382

NUMBER OF CAMPS VISITED, BY PERSONNEL OF MIGRANT HEALTH PROJECT, BY WEEK

NEW JERSEY 1964

COUNTY	NUMBER OF CAMPS VISITED																
	Week Beginning																
	July				August					September				October			Nov.
	6	13	20	27	3	10	17	24	31	7	13	21	28	5	12	19	16
All	91	121	65	125	102	104	98	70	56	21	44	22	38	28	7		8
Atlantic			3	6	13	7	13	4	2		3	1		5	3		
Burlington	3	9	1	6	10	8	1	5	3				1				
Camden			1	5		14	16				1	1					
Cumberland	21	18	15	10	19	19	22	20	14	2	8	5	6	6	2		8
Gloucester	23	21	6	29	1	2	2	1	2	3	4	2	2				
Mercer						1											
Middlesex	7	7	8	8	10	16	18	7	6	6	12	1	23	11	1		
Monmouth	1	30	16	28	25	14	25	26	16	5	3	1		1			
Salem	36	36	15	33	24	23	1	7	13	5	13	11	6	5	1		

CENSUS OF CAMPS VISITED BY PERSONNEL OF MIGRANT HEALTH PROJECT, BY WEEK - NEW JERSEY 1964

	NUMBER OF PERSONS IN CAMPS VISITED																		
	Week Beginning																		
	July				August					September				October				November	
County	6	13	20	27	3	10	17	24	31	7	13	21	28	5	12	19	20	3	10
All	639	777	516	935	555	508	340	221	242	66	119	129	154	114	22				
Atlantic			72	97	141	58	111	88	37		32	2		46	22				
Burlington	41		67		4	27	2	5					2						
Camden			1	15		58	40				20	6							
Cumberland	73	476	218	83	136	229		36	15					3					
Gloucester	262	83	67	253	11	18	43		12	14	20		22						
Mercer																			
Middlesex	13	7	21		13		71	14			17		71	12					
Monmouth	23	90	29	253	194	31	73	27											
Salem	227	121	41	234	56	87		51	178	52	30	121	59	53					

RATIO OF OCCUPIED TO AVAILABLE HOUSING UNITS IN CAMPS VISITED BY PERSONNEL OF MIGRANT HEALTH PROJECT NEW JERSEY 1964

HOUSING UNITS	WEEK BEGINNING																		
	JULY				AUGUST					SEPTEMBER				OCTOBER				NOVEMBER	
	6	13	20	27	3	10	17	24	31	7	14	21	28	5	12	19	27	3	10
Available	211	268	169	309	272	235	74	44	32	14	19	10	115	62	5				
Occupied	175	218	162	287	226	181	65	39	20	11	17		16	25	5				
Ratio Occupied/ Available	.83	.81	.96	.93	.83	.77	.88	.89	.63	.78	.9	0.0	.14	.4	1.0				

NUMBER OF CAMPS IN WHICH HEALTH EDUCATION GIVEN BY PERSONNEL OF MIGRANT HEALTH PROJECT

NEW JERSEY 1964

COUNTY	TOTAL	NUMBER OF CAMPS		
		HEALTH EDUCATION		
		MIGRANTS	GROWERS	OTHER
All	453	270	301	4
Atlantic	30	5	30	
Burlington	17	12	5	
Camden	30	5	28	1
Cumberland	75	43	35	1
Gloucester	79	50	58	
Mercer	9	8	8	
Middlesex	49	40	41	2
Monmouth	56	47	21	
Salem	108	60	75	

Appendix V

MONTHLY INTAKE OF CASES, MEDICAL SOCIAL SERVICES
MIGRANT HEALTH PROGRAM NEW JERSEY 1964

Month	Number of Cases	Month	Number of Cases
Total	124		
January	13	July	19
February	0	August	22
March	1	September	16
April	7	October	11
May	4	November	9
June	15	December	7

DISTRIBUTION OF CASELOAD BY COUNTY OF CAMP RESIDENCE
MEDICAL SOCIAL SERVICE MIGRANT HEALTH PROGRAM
NEW JERSEY 1964

County	Number	State Health Districts Northern	 Central	 Southern
Total	124	3	25	96
Atlantic	2			2
Burlington	4		4	
Camden	8			8
Cumberland	19			19
Gloucester	31			31
Hunterdon	1	1		
Mercer	2		2	
Middlesex	12		12	
Monmouth	7		7	
Morris	1	1		
Salem	36			36
Warren	1	1		

DISTRIBUTION OF CASELOAD BY SOURCES OF REFERRAL
MEDICAL SOCIAL SERVICE MIGRANT HEALTH PROGRAM
NEW JERSEY 1964

Source of Referral	Number	Percent
TOTALS	124	100
Public Health and School Nurses	54	44
Clergy	4	3
Health Agencies	28	22
(Local) Social Agencies	1	1
Physicians	7	6
Farmers	3	2
Crew Leaders	1	1
Police	4	3
Self	4	3
Relative	1	1
Commonwealth of Puerto Rico	12	10
Sanitarian of Migrant Labor Bureau	1	1
Interested Persons	4	3

DISTRIBUTION OF CASELOAD BY MAJOR PROBLEMS
MEDICAL SOCIAL SERVICE
MIGRANT HEALTH PROGRAM
NEW JERSEY 1964

Major Problems	Number	Percent
TOTALS	166	100
Financial	27	16
Employment	4	2
Physicial Health	89	54
Mental Health	7	4
Mental Retardation	4	2
Family Relationships	1	1
Mental Adjustment	8	5
Personal Adjustment	4	2
Housing	4	2
Transportation	6	4
Legal Aid	10	6
Substitute Case of Children	2	2

NUMBER OF CASES CLOSED - MEDICAL SOCIAL SERVICES MIGRANT HEALTH PROGRAM NEW JERSEY 1964

Reasons Closed	Number Cases
TOTAL	109
Service Completed	48
Referred to Other Agencies	19
Made Own Plans	30
Undetermined	12

TOTAL CASE WORK INTERVIEWS - 109 CLOSED CASES MEDICAL SOCIAL SERVICES MIGRANT HEALTH PROGRAM NEW JERSEY 1964

	Number of Case Work Interviews		
With	Total	In Person	Telephone
TOTAL	1,029	527	502
Client	272	261	11
Colateral	757	266	491

SERVICES RENDERED TO CLOSED CASES - MEDICAL SOCIAL SERVICE MIGRANT HEALTH PROGRAM NEW JERSEY 1964

Type Service	Number of Cases	Percent of Cases Served
TOTAL	109	100.0
Case Work	88	80.0
Professional Consultation	50	46.0
Financial Assistance	19	17.0
Other	6	6.0

NEW JERSEY STATE DEPARTMENT OF HEALTH

MIGRANT HEALTH PROGRAM

Conference on Hospital Social Service

Problems Related to Agricultural Migrants

12/18/63

For the most part discussion centered around problems arising in connection with the needs of migrant farm workers for hospital and post-hospital care. The one recurrent theme was the need to open channels of communication and establish an effective working relationship between the hospital and other resources in the community, and thus to have recourse to the use of such facilities and services as may be indicated to adequately meet the needs of these people.

As background information preliminary to this discussion, the following significant points were made:

1. Population mobility is a phenomenon of modern society which contributes to the general economy but at the same time leaves many problems in its wake. Society has an obligation to find ways of dealing with the human and social problems arising out of this dilemma.

2. Migrant farm workers are a people who live in a social vacumm -- a people who have no roots either in New Jersey or in Florida. They are not accepted by the local community here or in the South. Despite the fact that they constitute an essential part of an essential industry in this State, they are not accepted and cannot turn with confidence to the community for help in meeting their emergency needs.

3. Far too little factual information is currently available as to the exact nature of the problems and needs of these people. A survey conducted during the 1960 migrant season revealed that 10% of the migrant families had required hospital care, yet a canvass of the hospitals in the area did not produce much information as to either the source of funds for this care -- i.e., the amounts actually paid by or in behalf of migrant farm workers, and the amounts

covered by hospital appropriations -- or any of the complicating social problems or needs that have had to be taken into consideration in planning for post-hospital care.

4. More recently, the beginnings of a plan have been worked out whereby the hospitals have been asked to identify migrant farm workers under care, preferably at the time of their admission. This information is relayed to the local public health nurse who makes the necessary home visits to determine the nature of the family situation as it relates to the current needs of the patient and to plans for his post-hospital care.

In the discussion that followed, a variety of problem areas and service needs were identified as follows:

1. The need for hospitalization. When the use of government appropriations for hospitalization is limited to residents, whether they be indigent or medically indigent, and the hospital is faced with the question of applying such funds to the care of migrant agricultural workers, experience has shown that the latter are likely to "fall between the cracks".

2. The need for post-hospital care. When the hospitalized migrant is declared "ready to go home" and the treating physician has outlined the care he will require, the hospital social worker then discovers that he has no home to go to. In other words, at this crucial moment when it is expected that the patient will be leaving the hospital, it is learned that: he needs housing; he has no income with which to pay for it; lacking residence (for Disability Assistance), he "cannot be picked up" by county welfare; and that while some municipal welfare departments provide emergency care, others do not, or may accept referral of a case for service only to find there is no possibility of providing it. When faced with emergencies of this kind where does the social worker turn for help?

3. The need for community planning. Within the migrant agricultural group there is a vast reservoir of unmet needs. The migrant farm worker in the hospital is harassed by the same problems and needs that distress any other hospitalized persons in the community. In addition, there are other sick migrants who find themselves literally "put out on the street without a nickel" when they leave camp, as families have to move on with the crew leader when farmers no longer want to hold them on the premises. By and large, the migrant farm worker particularly needs help at the point when he is separated from the group.

To adequately serve these people requires community-wide planning. Society has to find ways of meeting the needs of all people wherever they may be, and of providing for all uniformly through preventive and rehabilitative services. An objective as broad as this cannot be accomplished by any one group alone as the needs cut across many different interests. It is harder today to mobilize a community to help newcomers. It is often a matter of gradual education and interpretation locally, as well as local implementation. If properly motivated, the community is likely to take appropriate action.

4. An ounce of prevention. An encouraging note was introduced by by one hospital representative who reported that after the housing requirements in a given area had been raised, the hospital had fewer patients from that area than formerly--an example of how preventive and rehabilitative services made available uniformly to all people within a given group can effectively cut down the number of individual problems that would otherwise stem from this group.

5. When mental illness strikes. The representative from the State Hospital at Marlboro generously offered that institution's assistance in situations where mental illness is suspected and commitment seems indicated. In such instances, the Hospital's Admission Service, which covers Middlesex, Ocean, Union, and Monmouth Counties, screens cases prior to admission to see what alternative plans, if any, might be made. The Hospital will gladly extend this service to migrants in the counties mentioned above.

   In addition, any hospital patients who are found to be potentially employable may be placed in a family care home as the first step in their return to the community. This service may also be extended to migrant agricultural workers who fit into this category. Ordinarily when such situations occur, financial responsibility is transferred from the hospital to the county welfare board. However, in the case of migrants the need to transfer such responsibility out of the State Hospital would constitute a serious handicap as the individual concerned would have to meet certain residence requirements (if the county were to be involved) or to have legal settlement (if the municipality were to be involved).

During the course of this discussion, several suggestions were made as to steps that might be taken to eliminate some of the roadblocks that now impede services to migrant farm workers. Such suggestions were directed towards:

1. The need to effect early identification of the hospitalized migrant. As indicated above, the hospital social worker is often unaware of the presence of a migrant farm worker in the hospital until the day of his discharge when the nature of his needs combined with his complete lack of resources precipitates an emergency situation. Identification of the migrant at the time of admission to the hospital, or very shortly thereafter, was strongly recommended. This would enable the hospital social worker to do some pre-discharge planning, in collaboration with the medical staff, and to explore the suitability and availability of certain community facilities so that by the time the patient would be actually ready for discharge, plans for his post-hospital care would be pretty well worked out and would present no difficulty in implementation. However, this does not happen automatically.

   Ordinarily when the patient goes into the hospital, he stops first at the Admitting Office where, for purposes of identification, he gives as his local address that of the farmer for whom he is working. No one in the hospital questions this. Given such an address, the hospital would do well, especially during the migrant season (April to September), if it would question further to see if the patient has actually been living at this address or if he has recently arrived there.

2. The need to place on the farmer his share of responsibility in this matter. In general, attempts to identify the hospitalized patient through the farmer have not been helpful as the farmer is not likely to know the names of the migrants working for him, or be able to identify them except "when they are brought to him bodily". As was further brought out, the farmer does not usually maintain any records of the migrants he has brought to his farm, nor does he keep any payroll records by which he might identify them. Frequently he does not register them with social security so that they carry no identification from that source despite the fact that many of them have returned to work for the same farmer for years.

   Out of this discussion came specific recommendations that the farmer:

   a. should have responsibility for knowing whom he brings into New Jersey through the crew leader;

   b. should register every migrant who works for him and provide him with an identification card when he goes into the hospital;

   c. should he require to maintain a record of his payroll covering all migrants working for him. (This recommendation will be presented to the Migrant Labor Board and the local farmer groups).

3. The need for the Federal government to provide some incentive to States for that part of the migrant program that requires payment for services to non-residents. By and large, States, in providing services to needy persons, have some basic residence requirements which the migrant farm worker cannot fulfill. Despite the prototypes and prejudices long associated with mobility and migrant labor, we are now beginning to see it for what it really is -- a phenomenon of the present-day world which must be seen within the framework of the whole world struggle as a necessary factor in our economy and as part of the process of bringing about social change.

   What happens to these people who have been cut off from their normal base -- these people who have dared to pioneer? Could it be, as suggested here, that the Federal government could contribute at least a partial answer to this problem? Certainly all States are becoming more and more aware of this situation and of the need to do something about their residence requirements.

In bringing this statement to a close, it can be safely said that while there was no attempt to take a formal vote on any of the specific suggestions made during the course of the discussion, the group gave ample evidence that it was in full accord with these proposals.

Leonora Rubinow
Official Conference Recorder
Supervisor of Training and Consultation Services
Bureau of Public Assistance
New Jersey State Department of Insitutions & Agencies

February 24, 1964

Miss Rose Galaida, A.S.S.W.
Migrant Health Program
Department of Public Health
Trenton, New Jersey

Dear Miss Galaida:

Enclosed you will find a synopsis report of the Proceedings and Discussion Session of the Conference on Hospital Social Service Problems related to Agricultural Migrants held February 7, 1964 which incorporates the areas of concern as well as questions of the representatives of our Social Service Department who attended. We found this conference to be thought provoking and quite informative. It was a vivid reminder of the continual need for social action in making our communities aware of the needs of this minority group and also the valid contribution which we as social workers can make in identifying these persons and their social welfare needs.

It was indeed a unique opportunity to attend the conference, participate and become acquainted with you personally. We will look forward now to receiving the referral forms about which reference was made at the conclusion of the conference.

Very truly yours,

(Mrs.) Margo Perry, M.S.W.
Psychiatric Social Worker
New Jersey State Hospital At Ancora
(Official Recorder)

Enclosure

NEW JERSEY STATE DEPARTMENT OF HEALTH
MIGRANT HEALTH PROGRAM

CONFERENCE ON HOSPITAL SOCIAL SERVICE PROBLEMS RELATED TO AGRICULTURAL MIGRANTS

February 7, 1964

A. Synoptic Report of Proceedings and Discussion Session

The Conference on Social Service Problems related to Agricultural Migrants availed those individuals, representatives of community agencies, hospitals and varied other community resources the opportunity of gaining clarity regarding the functioning of the present New Jersey Migrant Health Program as well as the function and efforts of two other community social welfare resources Bureau of Public Assistance and National Travelers Aid Assistance - in defining areas of need and the offering of services to agricultural migrants. In addition the conference offered those participating and in attendance the opportunity to share with the group experiences and areas of concern which implicitly and explicitly gave evidence of the myriad aspects of the social welfare problems of the agricultural migrant. Without doubt, all in attendance developed a renewed awareness of the numerous social problems of the agricultural migrant, the contribution all involved in working with these persons can make in further clarification of the needs of this group and the development of a more comprehensive understanding of the characteristics of those comprising this group as well as the need for continual efforts to develop current as well as new programs to meet the myriad social problems of the agricultural migrant.

The four participants gave concise over views of the programs of their departments and/or agencies in providing services of the agricultural migrant. Dr. William J. Dougherty, Director of Division of Preventable Diseases described the purpose and goals of the New Jersey Migrant Health Program. Highlighted was the ongoing purpose of bringing dignity to the labor of the agricultural migrant through the provision of rehabilitative and preventive health services. Continual efforts to determine the extent of need, improve means of providing preventive health services, and improve methods of reimbursement to hospitals for services to the agricultural migrant were characterized as major goals of this program. Mr. Thomas Gilbert, coordinator of the Migrant Health Program, described "contractual arrangements with general hospitals and their implications." Again emphasis was placed on the need for determining the extent and depth of the health problems of migrants, the effective manner of meeting their needs for hospitalization and the need for further exploration of methods of reimbursement to hospital providing services.

Mr. Ogden Glenn, Supervising Field Representative, Bureau of Assistance, New Jersey Department of Institutions and Agencies interpreted the law of residence-a public assistance policy of the state and the implications of the same in providing financial assistance to the migrant. Miss Jean Brown, Executive Director of Traveler's Aid Assistance, North Jersey in discussing Mobility-"its implications for individuals and families", traced briefly the history of the development of TAS from its inception in 1891 to present day. The function of TAS in providing services to mobile population, a group characteristically beset with social problems was described as preventive and rehabilitative.

Miss Rose Galaida, ACSW, Medical Social Worker, Migrant Health Program was moderator for the discussion period. The main areas of concern as evidenced in the questions and discussion of the group were (1) The registration of Agricultural Migrant Workers and their crew leaders, (2) Provision of Hospital Services to the migrant and problems of reimbursement, (3) Responsibility for the migrant: the community, the crew leader, the farmer, the migrant himself, (4) Social Welfare resources presently available and problems in utilization of same and (5) Availability of directory of resources providing services to the migrant on State, County and local level.

1. The Registration of Agricultural Migrant Workers and Crew Leaders---

The manner and mode of determining the number of migrant workers in an area as well as the availability of statistical data in this area was a significant area of concern to a number in the group. It was clarified that at this time crew leaders are registered, but individual migrants are not. Various community organizations and groups have conducted studies which provide information to this area, but evident is lack of uniform registration method. The Public Health Nursing Service in Cumberland County during the 1963 season conducted a statistical survey which incorporated the registering of agricultural migrant workers and their families. Follow-up visiting to the families was also conducted by this group. As a result of the forementioned information regarding family characteristics, home situation and needs was obtained. In Gloucester County, a similar service was provided by the Public Health Nurses. A study conducted through Rutgers University for the purpose of determining the number of camps and identify migrants in Camden County showed greater number of men, majority being affiliated with Glassboro Labor Camp, few women and few children.

Implications for development of services as derived from the discussion and questions in this area were (1) Need for development of method of registering migrants (2) Need for uniformity in mode of registration of crew leaders, migrant workers and their families on local, county, state and federal basis. Development of migrant registration program would provide a basis for obtaining information which would allow for further clarity in identification of the migrant worker as well as a more comprehensive determination of the extent and depth of his social problems and social needs.

II. Provision of Hospital Services to the Migrant and Problems of Reimbursement.

Under the New Jersey Migrant Health Program studies have been made to determine the extent and kind of health needs of the migrant, the preventive health services, available and offered, and the frequency of hospitalization services to migrants. Prior to the establishment of contractual arrangements with general hospitals under New Jersey Migrant Health Program, local community hospitals were the sole source of providing care for the indigent migrant. Presently the Department of Public Assistance will pay $8.00 per day for migrant's hospital care, if the person is determined to be an indigent migrant. Difficulty in establishing an individual's status of being a migrant and obtaining information required by Department of Public Assistance to establish eligibility has led to situations wherein hospitals have no means of being reimbursed for services given. It was recommended that problems in this area be referred to the Migrant Labor Board for study as well as action.

Factors contributing to problems in this area appeared to stem from the basic lack of clarity regarding identity of migrant, and full comprehension of manner of utilizing resource available to provide reimbursement. Continued efforts to find more effective means of reimbursement for hospital services is needed. Also more comprehensive data on the extent and kind of hospital services proveded would be significant to further development in this area.

III. Responsibility For the Migrant, Community, Crew Leader, The Farmer, Migrant Himself---

Discussion and questions related to responsibility for the welfare of the migrant engendered the following ideas:
The Community has a responsibility to this rather mobile unsettled group of people in determining the extent, kind and depth of their health and social needs, developing and improving programs and services to meet these needs, clarify extent of responsibility assumed by community, and help migrants become aware of services available. Means of gaining crew leaders cooperation in assuming responsibility for migrants under his leadership as well as determining what responsibility he has to the migrants needs to be explored. Assurance of responsibility for welfare of migrant worker on part of farmers is difficult to determine or regulate at this time. While it is recognized that the community, crew leaders and farmers have responsibility for the migrants welfare, this does not negate the migrants individual responsibility for himself.

IV. Social Welfare Resources Presently Available and Problems in Utilization of Same:

Throughout discussion the basic difficulty repeatedly highlighted was the lack of clarity about existent resources providing services to the migrant and manner of properly utilizing the same. Further interpretation of these existent services would be of value.

V. Availability of Directory of Resources Providing Services to Migrant on Federal, State, County and Local Level

Presently the only such listing available is information compiled independently by the Public Health Nursing Services in various counties. The value of such a directory is recognized but no planning for compiling such has been undertaken as yet.

Margo Perry, M.S.W.
Psychiatric Social Worker

New Jersey State Department of Health
Migrant Health Program
Social Service Unit

Report of June 2, 1964 Conferences and Workshop for Hospital Social Workers in Central State Health District - held in Trenton, New Jersey.

This meeting related to joint efforts and planning for services to migrant workers and was attended by thirteen representatives of various general hospitals in the Central Health District area. It was evident from the outset of this conference that specific steps and practical approaches in the direction of helping migrants were being sought and would be attempted during the summer season of 1964. Our previous conference had prepared the group to begin its deliberations with a common purpose and to follow through its activity with some attempts at improving conditions which would make hospital services more readily available to the migrant in New Jersey.

Miss Galaida and Dr. Dougherty both emphasized the crucial issue of lack of self identity which plagued the migrant worker. Significantly they spoke of the migrant "living miserably and dying not knowing why" of "deprived people unaware of the resources available to them," and "of the need to treat people with respect and dignity." As people in this country, they have certain rights and are protected by certain laws and also carry certain responsibilities. Our job is to enable them to become aware of both their rights and responsibilities.

The Resource people indicated below spoke at the first session:

Charles G. Yersak, Chief, Migrant Labor Bureau, N.J. State Dept of Labor.
Leo Forrester, Asst. Chief, Farm Placement Bureau, N.J. State Dept. of Labor
Robert W. Alexander, Supvervising Field Representative, N.J. State Dept. of Institutions and Agencies
John Finney, Field Representative, Bureau of Assistance, N.J. State Dept. of Institutions and Agencies
Miss Elfriede Friese, Asst. Supervisor of Field Services, Div of Mental Retardation, N.J. State Dept of Institution and Agencies
Major Edwin J. Freech, Commanding Officer, Salvation Army
Miss Mae Rosalee Brown, Executive Dir. Visiting Homemakers Assoc. of New Jersey, Inc. N.J. State Dept. of Health

Mrs. Ida Z. Alphin, Supervisor of Day Care Services, Bur. of
Children Services, N. J. Dept. of I and A.
Joseph Toll, Official Recorder - Dir. of Psychiatric Social
Services, N. J. State Hospital, Marlboro, N. J.

These people contributed much to the conferees background and awareness of the many efforts made to improve the conditions and protect the migrant himself from exploitation and abuses. Mr. Yersak spoke at some length of the New Jersey State code on migrants which was written in 1945. It is considered to be one of the best in the country. The first code was chiefly due to the agressive efforts of women's organizations to reform the intolerable conditions of migrant workers living in the woods without water or even a tent, these women were chiefly Jewish and Catholic Women's groups as well as State Labor organizations and the Consumers League of New Jersey.

In 1945 a new law came into being known as Public Law 1945 - Chap. 71. This law was administered from 1945 to 1955 and affected chiefly displaced persons and migrant labor. Housing and sanitation were the main factors which concerned the law enforcement agency during its early efforts to have employers of migrants comply with the code. The significant point was made that agricultural users of migrant labor had to be convinced the law was useful to both employer and employee alike. John Scholl, The Senator from Gloucester, ran into problems of outside privies, pitcher pumps and many camps appearing in the woods where the public could not see them. It was very difficult to enforce proper conditions for housing, bedding and sanitation from 1945 to 1955 when activity of the Migrant Labor Code was being worked through by Senator Scholl.

In 1956 Mr. Yersak became the new chief in charge of enforcing the code and a new administrative structure was established. In 1959 another change was made in the Migrant Labor Code itself. Hot water became mandatory as a condition of sanitation for people in the camp of 8 persons or more. Crew leaders who housed people in camps were required to register with the Labor Bureau. The potato group section of Monmouth and Middlesex Counties took this matter to the Superior Court and the judge ordered "a showerhead for every 20 people after a hard days work". Within a short period of time 73% of the camps had complied. The Bureau is now enforcing regulations that all camps have hot and cold water. It is estimated that last year 25,000 people were housed in migrant labor camps in New Jersey. It is difficult to get accurate statistics due to excessive mobility.

Mr. Alexander, Department of I and A, Bureau of Assistance, pointed out that the migrant can qualify for AFDC aid as New Jersey does not have residence requirements for this program; that general assistance, on the other hand, is a local responsibility and each municipality sets up its own eligibility requirements.

Mr. Alexander pointed out, there should be no hesitation in helping migrant patients file applications for public assistance with the welfare office of teh municipality where the camp is located. The New Jersey welfare law does provide for emergency aid (medical and other) for non-residents. Municipalities may request State reimbursement up to 80% of the cost of such assistance. This is often referred to as the 20-80 formula.

Moreover, a municipality may share the cost of hospitalization for seasonal agricultural workers and obtain reimbursement on the 20-80 basis up to the maximum of $8.00 per day. This is 80% of the $10.00 maximum per diem, to be allowed in the law for hospital care of non-residents. Obviously, this is another aspect of the law which needs revision for a realistic share of such cost. However, at this moment this is better than nothing and hospitals should bill the municipality for this available subsidy. This does not preclude municipal contribution at a more reasonable level but technically the Bureau of Assistance cannot share the cost beyond the maximum of $8.00 per day.

Local option is the "bug" in this situation. The constitutionality of the negation of a State law by local ordinance has yet to be tested.

In the event of a non-resident's or seasonal worker's death, the disposition of the unclaimed body is the responsibility of the municipality where the death occurs.

The municipality where the labor camp is located may be responsible for the burial when the seasonal worker is hospitalized in another community, with the knowledge of a crew leader and/or the grower.

Migrant agricultural workers should be made aware of their rights as citizens and of the provisions of the various public welfare laws by the social workers concerned with their welfare.

Crew leaders who exploit or fail to fulfill their responsibilities to crew members should be reported directly to the migrant labor bureau or via the migrant health project social service unit.

The Migrant Labor Bureau has very definite means for dealing with irresponsible crew leaders.

In cases where seasonal workers have no funds for prescribed medication, the matter should be brought to the attention of the migrant health project social service unit or the public health nursing organization serving migrants in the area. The hospital social service workers were urged to use the referral form provided by the migrant health project social service unit for referring seasonal workers, for discharge planning and follow-up service or when social consultation is desired, regarding other problems of migrants who are under care.

Major Freeh of the Salvation Army, Trenton unit urged the conference members to contact him for assistance on a short term basis and emergencies where existing agencies are unable to pick up their responsibilities immediately. Mr. Forrester spoke briefly of how to use the employment agencies for seasonal workers and suggested the use of this term rather than migrant workers. He pointed out that the migrant worker was not entitled to unemployment insurance and that his bureau is concerned with keeping the migrant employed. In order to facilitate their employment they keep in contact with other states and follow the movement of the migrant, as well as recruit migrant labor for New Jersey from other states. Incidentally they interpret to the migrant from other states some of the regulations and practices in New Jersey i/e. the Fuel Tax which affects large numbers traveling to the State.

Miss Friese of Mental Retardation urged that conference members could call her for consultation where a family member or child is diagnosed as mentally retarded "don't stop planning because the lack of residence where institutionalization is required". She suggested that we work through the district offices in Trenton or Hammonton in South Jersey.

Mrs. Brown, of the Visiting Homemaker Association, briefly discussed a tentative program being explored by the Migrant Health Program and her agency. There is a possibility that female migratory workers could be trained as homemakers and home health aides and work with released hospital patients in their specific camp. If women could be trained, this would help the hospitals with one problem, "where to send the patient". These trained homemakers could also be used in training other migrant mothers to improve their home management skills even though their housing facilities are quite often small and in deplorable condition. These trained homemakers could also plan for the care of children if and when a mother has to be hospitalized.

Ways of establishing identification were explored and current difficulties reviewed.

The discussion pointed up the fact that most serious obstacles to any identification plan for seasonal agricultural workers is one common to all minority groups; namely, they do not wish to be labeled and so set apart from the rest of the population. Admittedly, this is a healthy reaction in a democratic society. Migrant agricultural workers resent being considered as second class citizens.

Many problems of the non-resident farm workers were attributed to the following:

1. The inaccessibility of the labor camp, and, therefore, isolation from regular community life.

2. Lack of adequate housing and facilities for decent living for both individuals and/or families.

3. The lack of provision for proper supervision and care of children of working mothers.

4. Lack of opportunity for wholesome recreation and/or constructive off-duty activities.

Consequently, they are left with the only readily available alternatives under the circumstances, namely, card games, gambling, drinking and other undesirable indulgences which too frequently necessitate weekend emergency hospital care.

Hospital personnel were encouraged to contact the Bureau of Farm Placement, Phone 292-2244, and/or the Migrant Labor Bureau, Phone 292-2341, for help in identifying agricultural migrant workers, crew leaders, and employer growers, etc.

Mr. Yersak translated the definition of the migrant agricultural worker into more meaningful terms for general public understanding. Both definitions follow:

1. Migrant Labor Act Definition

   The term "seasonal worker", "temporary worker" and "migrant worker" shall not include any person who is or shall have been a resident of this State and who has had or shall have had his all-year-round dwelling place in this State for one year or longer and who dwells in said all-year-round dwelling while engaging in any seasonal or temporary work.

2. Mr. Yersak's Interpretation

   The above definition is interpreted to mean that a seasonal worker, temporary worker and migrant worker is a person who, even though a permanent resident of this State or any subdivision thereof or from any other state or subdivision thereof, leaves that permanent residence or dwelling place while employed in any seasonal or temporary work during that period of seasonal or temporary work and is housed by his employer or his agent is, in fact, a migrant worker. The housing facilities provided by the employer or agent are, in fact, a migrant labor camp whether rent is paid or not.

Hospital social service workers are often frustrated when they are faced with need for post hospital planning for indigent migrant agricultural workers who have a need for temporary financial assistance or convalescent care. The negative attitude of the community welfare directors to the human needs of seasonal workers is difficult to overcome.

Miss Galaida highlighted the services rendered by various resource personnel who have participated in our conferences. They should be contacted whenever there is real need for services or guidance on behalf of seasonal people.

The group emerged as a cooperative contributing working body concerned with persons in transit and motivated to secure ways to establish health and welfare services for the well being of migrants during their sojourn in New Jersey.

Joseph F. Toll
Director of Psychiatric Social Service
State Hospital, Marlboro, New Jersey

NEW JERSEY STATE DEPARTMENT OF HEALTH
Migrant Health Program
Workshop for Hospital Social Workers
Attendance List - June 2, 1964

Mrs. Barbara Cochrane	Rancocas Valley Hospital	Willingboro
Mrs. Jane Brooks	Trenton State Hospital	Trenton
Mrs. M. Morgan	St. Francis Hospital	Trenton
Mrs. J. Schiller	St. Francis Hospital	Trenton
Mrs. Phyllis Blackburn	Roosevelt Hospital	Menlo Park
Mrs. Jean McCormick	Mercer Hospital	Trenton
Joseph Damiano	St. Peters Hospital	New Brunswick
Mrs. Bessie Robbins	Fitkin Hospital	Neptune
Joseph Toll	N. J. State Hospital	Marlboro
Miss Angie Tuzzio	Monmouth Medical Center	Long Branch
Mrs. Barbara Cook	Paul Kimball Hospital	Lakewood
Mrs. Grace Fry	Princeton Hospital	Princeton
Mrs Margaret Liebenberg	Middlesex General Hospital	New Brunswick
Mrs. Ida Z. Alphin	Department of I & A	Trenton
Samuel Mopsik	NTAA, N. J. Migrant Health Program, Mobile Social Service Unit	Woodstown

Resource persons on list with the program - all attended except Rev. R. Van Dyke.

PROCEEDINGS OF THE SECOND WORKSHOP FOR HOSPITAL SOCIAL WORKERS CENTRAL STATE HEALTH DISTRICT

This workshop was held on December 2, 1964. It was opened with a short welcoming address by Mr. William R. Peebles representing Dr. Roscoe P. Kandle, Health Commissioner. Miss Rose Galaida gave a short introduction and welcome.

One of the main points that Miss Galaida emphasized was the fact that the Migrant Health Program works with disadvantaged people, many from a different culture, some of whom appear to be bi-lingual. She reminded the group that there is a tendency to assume that those bi-lingual people understand what we are saying to them when in reality, they do not and will not admit it.

Mrs. Matilde Perez de Silva spoke on the inherent culture factor related to participation in medical care and discussed medical care in Puerto Rico and the role of the social worker there. Medical services in Puerto Rico are free for those who need them. There are no eligibility requirements or means test. There is no tendency, however, to take advantage of this government program or abuse it because paying privately for these services is a status symbol and where people can, they pay privately. The Puerto Rican who comes to this country and needs medical care is usually bewildered by the "red tape" and the question, "who is going to pay?" In Puerto Rico, medical care, social services, etc., are government-sponsored. Records are not segmented so that patients are not segmented and an attempt is made to make all services easy and simple for the patient. Puerto Rico now has health centers containing all the clinics, consequently, one record is used for all services in which a patient is treated. Mrs. deSilva said, "We are anxious for people to use the services; we do not make hurdles -- we remove hurdles."

Mrs. deSilva emphasized the need to teach patients how to use the available facilities. They must be taught self-help but this can only be achieved if they know how to use the facilities that are available. It is also important that they be told what to expect so that each step in their care does not come to them as a surprise. People out of their environment are not stupid but they do have to learn -- to be taught.

Mrs. deSilva gave examples of differences in culture which must be recognized. For example, the Puerto Rican is used to eating a small breakfast and a hot lunch. The social worker in the hospital must interpret this facet of the culture to our hospitals. Breakfast is really not appealing to the Puerto Rican culture. The Puerto Rican is used to having an extended lunch which usually lasts two hours. She gave an example of a Puerto Rican on a farm in the state who appeared to be losing weight. He complained to the social worker that each time he took his lunch and sat down to eat, the farmer would gesture to him to get up. When the social worker took this up with the farmer, he said that he culd not understand whey this worker insisted on eating his lunch in a patch of poison ivy. Consequently, each time he would see the worker sit down, he would motion to him to get up. This situation points out the difficulty in communication especially when the people concerned think they understand what is going on but really do not.

It is important for the medical social worker to know that traditionally, the Puerto Rican is afraid of hospitals. They are accustomed to care at home and to them especially those who are less sophisticated, going to the hospital is associated with dying. Consequently, with the people with whom we deal, suggesting hospital care could be very threatening and fear-inducing. The sick are visited by many friends and relatives who do not hesitate to express their emotions.

Mrs. deSilva spoke of the Puerto Rican inherent lack of sense of time. They have a habit of being late. She cautioned against telling the Puerto Rican to keep an appointment at "such and such" a time, "sharp" because to them this usually means come between "such and such" a time. For example, you might tell them to come at 2:00 o'clock and to them this means possibly between 2:00 o'clock and 2:30. She suggested that we tell them to come earlier than we really expect them and in that way a schedule can be maintained more easily. You should say, "come before 2".

Puerto Rico has a shortage of houses. The average size of the family is 5.4, while in the United States it was quoted to be 1.98. The Government is carrying on a double-pronged housing program. Included is: the building of individual public houses and making available tracts of land where interested tenants may move their houses or build. This is a phase of the "self-help program", which operates on the theory of "teach people to help themselves." The Government provides help with the building of homes, even providing some of the needed materials. These homes still have no indoor plumbing but are a vast improvement over the ones available before this program was begun.

Until recently, the Puerto Ricans placed a lot of confidence in the use of canned fruits and vegetables. They were supposed to be cleaner. Now the Government is teaching them the value of fresh fruits and vegetables and are encouraging them to eat the fresh products.

Miss Ann Callaghan, Director of Social Service, West Jersey Hospital, spoke about the role of the medical social worker in the modern hospital. She traced the history of the Social Service Department at West Jersey Hospital in Camden. This service was started in 1957. Its original relationship was with the Psychiatric Service. It then was extended to the Crippled Children's Service and was later to the neuro-psychiatric and cardiology services. It then enveloped the cardiac-pediatric service also. At the present time, the Social Service Department is working with the Geriatric Program and has difficulties since Geriatric patients must be transferred from the hospital to other institutions. She pointed out that there are very few Puerto Rican Geriatric patients in the hospital. She stressed that they do run into language problems especially if an interpreter is not available. By-in-large, Miss Callaghan stressed the fact that Puerto Rican patients usually follow through with appointments. She suggested that patients who spoke a different language even though they apparently were bi-lingual, be given time to internalize the suggestion of the Social Worker, and the patient must have the milieu to express his feelings about these suggestions. She stressed the need for sensitivity of the worker to directions being given in English to someone who does not speak English. Mrs deSilva added here that the social worker's attitude of helpfulness, interest and concern is sometimes more important than the ability to speak the language.

Sister Mary Aquinas, a panel resource speaker described the services of the Catholic Welfare Bureau of the Trenton Diocese. They work with people from the "cradle to the grave." They have other offices in Red Bank and Fords and operate a guidance clinic in New Brunswick. In the Trenton Diocese they operate a Child Guidance Clinic and a Family Service Program. Their services include marriage counseling, adoption services, work with unmarried mothers, day care program for working mothers, delinquent children up to sixteen years of age and problems of the aged. The Mount Carmel Guild is the source of the services in Trenton.

The Rev. H. Van Dyke discussed the work of the Migrant Ministry which has 4,000 staff people plus interested volunteers throughout the country. The Migrant Ministry cooperates with all public and volunteer organizations working with Migrants. He stressed the fact that we all must cooperate in an effort to break down opposition and suspicion against the migrant worker. He picturesquely called their program "The Scattered Church." The Organizations cooperating in the program represent a wide cross-section of interest including: recreation, school boards, nurses, doctors, teachers and many other groups. Rev. Van Dyke thought that the new plan requiring crew leaders registration is a "good brick in building rapport."

Mr. Chickachop interestingly stated, I will tell you a bit about your bureau of Children's Services. The agency has a service that cares for the child from embryo to the age of 21. Included in these services are the following: foster program, services to children in their own homes, adoption, mobility groups, group care homes (5 to 8 children in a home), homemaker services, day care services, protective services and referral services.

The Bureau of Children's Services is always anxious to cooperate with other agencies. Mr. Chickachop distributed some interesting materials from the Bureau of Children's Services.

During the discussion Mr. Joseph Toll again drew attention to the language barrier problem stating that the interpreter sometimes says what he wants rather than what the client or worker says. At times the interpreter appears to be in competition with the caseworker. Mrs. Callaghan has found using a person working in the hospital, perhaps in the kitchen, gave better results than a trained interpreter.

In response to a direct question Mr. Chickachop explained the new law of protective services. When a family will not cooperate the Juvenile Court can order an investigation. The Court can make the child a ward of the Court and permit the Bureau of Children's Services to proceed with help for the children. Referring agencies are urged to prepare the families for the coming of the worker from the Bureau of Children's Services and thus "solicit" their cooperation.

Mrs. deSilva added some discussion of the role of the social worker in Puerto Rico where the services to patients are centered in the Health Centers. There are 7 District Hospitals on the Island and thus the patient can be kept as close to home as possible. Generally speaking the worker deals with cases as one would in any U. S. hospital. She visits the home to determine what the conditions are for return of patient from hospital. She said that much has been done in Puerto Rico in regard to prenatal care but there is much to be done since the infant mortality rate is still high - 8%. Some of the needs yet unfulfilled are education, a program to immunize against parasites and interpretation of the programs already available. She emphasized that actually the total death rate in Puerto Rico is lower than on the mainland. The emphasis at the present time is on education and how to use a State Integrated Program. The Four H is doing an excellent job with the children.

This workshop was actually a natural out-growth of the predecessor which was received with so much enthusiasm. It was requested by the participants in the first workshop that this second workshop be organized, and I think that one of its most important results was to emphasize to the participants that their working with the agricultural migrant is a needed service involving a specialized type of case work. The showing of the movie, "The Season People" blended perfectly with the tone of the meeting and lect the participants with the feeling that there must be more to come.

Recorders -- (Mrs.) Ida Alphin
Samuel Mopsik

NEW JERSEY MIGRANT HEALTH PROJECT

2nd WORKSHOP - HOSPITAL SOCIAL WORKERS

Attendance List

William Peebles	Exec. Asst. to Comm.	N. J. S. D. H.
Mrs. Margaret Morgan, RN	Dir. Soc. Serv.	St. Francis Hosp.
Mrs. Jane Schiller	Social Services	St. Francis Hosp.
Mrs. Betty Bernasco	Dir. Soc. Serv.	Helene Fuld Hosp.
Miss. G. Wieland, RN	Supervisor	Camden V.N.A.
Mrs. Barbara Cook	Dir. Soc Serv.	Paul Kimball Hosp.
Mrs Lorraine Hudak	Med. Secretary	Perth Amboy Hosp.
Mrs. Margaret Nebus	Registrar	Perth Amboy Hosp.
Miss Norma Fernandez	Social Worker	Com. Puerto Rico
Lionel Jimminez	Chief, Soc Serv.	Com. Puerto Rico
Miss Angie Tuzzio	Dir. Soc. Serv.	Mon. Med. Center
Miss Muriel Wescott	Asst. to Adm. of Pt. Services	Mon. Med. Center
Mrs. B. Robbins, RN	Dir. Soc. Serv.	Fitkins Mem. Hosp.
Mrs. Julia Keys, RN	Dir. Soc. Serv.	St. Peters Hosp.
Mrs. Grace Fry	Dir. Soc Serv.	Princeton Hosp.
John Toll, ACSW	Dir. Soc. Serv.	N. J. S. H.
Mrs. M. Liebensberg, RN	Dir. Soc. Serv.	Middlesex Hosp.
Miss Shirley Miller	Rehab. Counselor	Allenwood Hosp.
Mrs. Judith Meltzner	Dir. of Vol.	Rancocas Val. Hosp.
William Wilrigs	Hosp. Adm.	Rancocas Val. Hosp.

OBSERVERS OF WORKSHOP METHOD

Donald Benson	Dir. Pub. Rel.	N. J. S. D. H.
Mrs. R. Zwemmer	President	Consumers League
Mrs. L. Willette	Memb. of Exec. Comm.	Consumers League

All members of teaching and resource panels (5) and other participants listed on the program (4) were present including the Assistant ot the Hostess, Mrs. June Przecha.

State of New Jersey

DEPARTMENT OF INSTITUTIONS AND AGENCIES

BUREAU OF CHILDREN'S SERVICES

G. Thomas Riti, Chief
163 West Hanover Street
Trenton, New Jersey 08625

December 3, 1964

Mrs. Rose Galaida
211 East State Street
Trenton, New Jersey

Dear Mrs. Galaida:

I have enclosed two copies of the intake summary on the W_______ children.

Thank you very much for your cooperation and help. We are very pleased by the inter-agency cooperation we received on this case.

Sincerely yours,

Hilyard Simpkins
Caseworker

HS:ee

CASE NAME W_________, Ella, Eddie, Cliff, R. J., Joseph CASE # XNC 840-a-f PAGE 1.
and Dorothy

INTAKE SUMMARY

I. INTERVIEWS:

October 26, 1964 - telephone call from Mrs. Rose Galadia who is the social worker in charge of the migrant help program operating out of Trenton. Also on October 26, 1964, Mr. Mario Caceres called worker. He is a social worker in the migrant help program. Also on October 26, 1964, children were seen and taken to Dr. Akinson in Vincentown, New Jersey. R. J. W_______ went to the Children's Home, Joseph and Dorothy went to Mrs. Rowe's and Ella went to Mrs. Bracy. On October 27, 1964 telephone call with Mrs. Rowe. On October 29, 1964 telephone call with Mrs. Gunkel, school principal. On October 29, 1964, telephone call with Mrs. Galadia. On October 30, 1964, telephone call with Mr. Caceres. On October 30, 1964, telephone call with Mrs. Galadia - also October 30, 1964, interview with Mr. and Mrs. W_______. On November 2, 1964, telephone call to Mr. W_________. On November 2, 1964, children picked up from the Children's Home, brought to office, where met with the rest of the children and taken to Mr. and Mrs. W_________.

II. REQUEST AND PROBLEM:

On October 26, 1964, Mrs. Rose Galadia, who is the supervisor in charge of social workers for the Migrant Help Program of 211 East State Street, Trenton - telephone number 292-4033 - called worker and stated that there were six Negro children found by Mr. John Williams who is an inspector inspecting the L______ W_______ Labor Camp on Stelle Road, Chesterfield, New Jersey. She stated that Mr. Mario Caceres was going out to the camp to visit the children and find out what the situation was. She stated that he would call worker later and explain the situation. A few hours later, Mr. Caceres called worker and stated the following: he said that there were four Negro children at the L______ W_______ Labor Camp on Stelle Road in Chesterfield. He said they were between the ages of seven and fifteen. Mr. Caceres stated that there four children at the L_____ W______ Labor Camp - Ella Mae W_______ - age 15, R. J. W_______ - age nine (boy), Joseph Lee W_______ - age 8, and Dorothy J. W_______ - age seven. He stated that there were two older boys with the parents in Philadelphia or in Allentown, Pennsylvania (He wasn't sure). The number at which the parents could be reached, he said, was 215-699-3594. He stated the situation to be thus: the parents had gone to work on a farm in Philadelphia and the four children were left at the Camp under the supervision of Mr. Sammy L. Daniels. He stated that Mr. Daniels was a very sick man, suffering from asthma and that he also received $22.00 every two weeks from the public welfare. Mr. Daniels stated that he was unable to supervise these children. He also feels that the children are neglected. He said Mr. W_______, the children's father, went to Philadelphia about four weeks ago and used to visit them every week. Mr. W______ came last week-end - Saturday, and gave Mr. Daniels $7.00 to feed the children. Mr. Daniels said that this money is not enough to feed these children but he is trying to do his best. Mr. Caceres stated that the children had dirty clothing and do not attend any school. The condition of the home is very inadequate. In the bedroom, he found one double-decker and another bed made up of the spring and mattress on the floor, no sheets and only two blankets for all the children. The blankets and rooms are very dirty, the heater is not adequate to heat the home, as it is a small electric heater. He also stated that he felt that the children should be placed immediately for their own sake. Before leaving to go out to the Camp, worker and home finder found the following homes for the children: the girl age 15 would go with Mrs. Bracy, the boy 9 to the Burlington County Children's Home and the boy 8 and the girl 7 would go to Mrs. Rowe in Burlington. Worker also called Dr. Atkinson and arranged to visit his office in Vincentown with the children that evening. Worker then arrived at the L_____ W_____ Labor Camp on Stelle Road, Chesterfield and in talking with the oldest girl there, found that there were also two older boys. Eddie W______, age 13 and Joseph W______, age 12, also living in the home. They were at the present time, working on a nearby farm and would be back in about one-half an hour. Worker asked Ella Mae to pack all of the clothes that they had with them and told her that he would be right back, that he was going to the nearest telephone at the general store and call the office to see if he could find foster homes for the two other boys. Worker then proceeded to the telephone at the Chesterfield General Store and called Miss Jackson, his supervisor, and explained the situation. She asked him to wait by the phone and said that she would call the Burlington County Children's Home to see that they could take the children. Burlington County Children's Home agreed to take the two extra boys. Worker then went back to Camp and picked up all six children and took them to Vincentown to Dr. Atkinson. The children were then placed in the respective foster homes.

On October 30, 1964, worker then talked with Mr. and Mrs. W______. They explained the situation that had happened and they asked if the children could be returned so that they might go back with them to Florida which is their home. Worker stated that this would be possible and placed the children back with Mr. and Mrs. W______ on November 2, 1964.

III. CHILDREN'S HISTORY:

Not much is known about the children's history because of the short time we had them and also because the children themselves did not know their own birthdate and much of their background.

Ella Mae, female, Negro, Protestant, born March 12, 1950. She is 63-1/2 inches tall and weighs 121 pounds. She has a micro murmur of the heart and also Dr. Atkinson stated that she has one big cavity.

Ella Mae attends the eighth grade.

None of the children have but one complete change of clothes so complete clothing orders were given to them. When it was found that they would be returned to their parents within a short time, foster parents were asked to spend the necessary money to get them the basic necessities in their wardrobe.

Ella Mae, when in the presence of her brothers and sisters, acted much as a young girl would. She laughed, talked and was very loud. As Ella Mae was the last to be placed in a foster home, she was also seen by herself. At this time she was very quiet and serious and talked to the worker. Ella Mae liked her foster home very much and the new clothes that she got and didn't especially want to return to to her parents.

Eddie, male, Negro, Protestant, born May 10, 1952. Eddie weighed 150 pounds and was 66 inches tall. He seemed the most mature of the children and talked to worker readily, but when asked what his brothers and sisters birthdates were, he did not know. None of the children knew. Also, he had trouble deciding how many children there were actually in the family. He finally told the worker that there were four smaller children with the mother in Pennsylvania, one older brother who had taken care of them and had left to go to Florida and one child who had passed, or died of suffocation. Eddie is also in the eighth grade.

Cliff, male Negro, Protestant, born June 11, 1953. Cliff is also in the eighth grade. He weighs 136 pounds and is 65 inches tall. When examined by Dr. Atkinson, it was found that he also had a micro murmur of the heart. Cliff, also, as Ella Mae, did not want to return home after being in the Children's Home. He had enjoyed the stay, whereas Eddie wanted to return home.

R. J., male, Negro, Protestant, born September 13, 1955. R. J. weighed 66 pounds and was 52-1/2 inches tall. He has one cavity and also has a micro murmur of the heart. R. J. is in the fourth grade.

Joseph, male, Negro, Protestant, born November 18, 1956. He weighs 56 pounds and is 50-1/2 inches tall. He has an umbelical hernia and also a micro murmur of the heart. He is in the fourth grade and enjoyed his stay with Mrs. Rowe very much and was very sorry to leave that home. He told Mrs. Rowe several times that he did not want to go and wished to remain with her.

Dorothy, female, Negro, Protestant, born August 15, 1957. She is 48 inches tall and weighs 57 pounds. She attends the third grade. She, too, enjoyed her stay with Mrs. Rowe and did not wish to leave.

IV. FAMILY HISTORY AND RELATIONSHIPS:

Mother - Bessie Leigh (nee D_____) W______.

Father - Willett W______, born March 6, 1917. They gave their address as Room 1, Box 108, Tampa, Florida. They stated that the other children in the family were Jessie Leigh W______, born January 22, 1945. He is married and at the present time living in Florida. Virginia Leigh W______, born February 6, 1949. Roy L. W______, born January 1, 1960 and RobertEarl W______, born March 11, 1961.

When worker tried to call them at the number given to Mr. Caceres, there was no one by the name of Willett W______ at that telephone number so it was impossible to get in touch with the parents until they returned to the farm in Chesterfield. When talking to the parents, Mr. W______ stated that he had worked at Budweiser for five years in Tampa, Florida, but had gotten laid off in February of 1964 because of the Teamster's Union strike. He said there were eleven people laid off in the plant and he was one of the eleven but that there was a possibility that he would be re-hired very soon.

When Mr. W______ got laid off, he and his wife started picking tomatoes. At this time, Revered Deeks, who was a contractor came to him and told him that he would be able to earn quite a bit more money if he came up North. So, he gahtered his family together and Rev. Deeks brought them up on the bus from Florida. When they arrived here in New Jersey, Rev. Deeks did not have any job waiting as he had promised, so he took them to Mr. L___ W___ and told him of the situation. Mr. W___ happened to have room in his Camp and told them that he would find them work. So, they settled down in the L___W___ Labor Camp on Stelle Road, Chesterfield.

About four weeks ago, Mr. W___ decided that he had work for them in Pennsylvania. Since most of the crops were done in New Jersey, Mr. and Mrs. W______ went to Allentown, Pennsylvania with Mr. W___ to do some tomato picking there. They left the six children behind with the older brother and Rev. Deeks. They stated that they visited the children each week-end and that the children were staying with Rev. Deeks and the older brother and his wife in a home near the Camp. After they had visited on Saturday, October 24, 1964, Rev. Deeks and the older brother and his wife left the Camp for Florida without even telling them. Rev. Deeks had promised them and their family a ride back to Florida. They did not find out that the children were left alone until the state authorities had gotten in touch with them and the children had already been placed in foster homes. They returned to the Camp and talked with worker and explained to him that Mr. L___ W___ had room for them on the bus and promised to take them back on Wednesday, November 4, 1964. They asked that the children be returned to them before this time so that they might go back with them to Florida. Mrs. W______ was very upset and cried throughout the whole interview.

Worker asked Mr. W______ to call him on Monday and he would tell him for sure what day the children would be returned and if it was possible. Mr. W______ did this and worker returned the children on that Monday, November 2, 1964.

V. OTHER INTERESTED AGENCIES:

The Migrant Help Program of 211 East State Street, Trenton, New Jersey and the Board of Health.

VI. EVALUATION:

Placement of the children until the family can be found.

VII. IMMEDIATE PLAN:

Same as Evaluation - placement of children until the parents can be found, the situation to be evaluated.

VIII. LONG RANGE PLANS:

Contact the family, find out their circumstances and see of the children can be placed back with them as soon as possible.

(Miss) Mary J. Jackson
Supervisor

By: Hilyard Simkins
Intake Worker

Dated: December 2, 1964

HS/scb

NATIONAL TRAVELERS AID ASSOCIATION
AGRICULTURAL MIGRANT PROJECT

Six-Month Progress Report
May 1, 1964 - October 31, 1964

AREA COVERED

Our participation in the Project is limited to the Tri-County Area of Gloucester, Cumberland and Salem. Other than a small Child Guidance Center in each county, there is no voluntary social service agency available. The New Jersey Bureau of Children's Services has an office in Bridgeton. Other than that, the only welfare services available are through the local municipalities or the County Welfare Offices. This makes National Travelers Aid Association the first voluntary agency offering counselling services even on a limited basis in this area.

INTAKE

The following is a broad description of the intake which was assigned to me. More specific remarks and description will be made later in the report.

A total of 43 cases were assigned to N.T.A.A. These included 124 people served. Ethnically, 21 cases were Puerto Rican, 18 were Negroes, 3 were White and 1 was Mexican. Of the 43 cases, 20 were with single people or those in the area without their families. For the purpose of this report, I am describing all cases including those which remained open at the end of the six-month period. One hundred thirty-six camp visits or farm visits were made in regard to case work with the assigned case load. Thirty-six hospital visits were made with most of them occurring in September and October. Although most of the cases were referred by Public Health Nurses, there were 15 referrals made by Clergy, Health Coordinators, Physicians, Farmers, Crew Leaders, Police, and by the patients themselves. With the advent of a Puerto Rican Case Worker, Mr. Caceres, in August, 5 cases were assigned on a cooperative basis from an experimental point of view. This enabled me to help Mr. Caceres learn the area resources and to meet the resource people personally. It enabled me to interpret to the resource people, Mr. Caceres' position and relationship. On the other hand, he was able to give me a deeper insight into the problems and behavior of the Puerto Rican workers, from the point of view of their cultural background. He served also as an interpreter in conversations with Puerto Rican clients. Since four of the cases were men involved in the same automobile accident, our interviews were on a group level and consequently, there appeared to be no problems or complications in the use of two Case Workers for the interviews. The fifth case involved a man injured by an automobile while riding a bicycle. In this situation, I acted as a liaison for the Puerto Rican Case Worker with the community facilities since he was responsible for the case work relationship. Since the interviews were done in the hospital where there was no privacy, my participation, while he interviewed the patient, did not complicate the situation. While a cooperative assignment served a purpose I do not find this a satisfactory plan.

SAMPLE CASE SUMMARIES

The following are short summaries of a cross section of the cases handled during the past six months. It should be noted that some were referred too late for effective action. A few did not really fall within the domain of social service work. Some could not be followed as completely as warranted because of the short season.

"FLORA MAE"

This case was assigned on termination of another worker.

I saw Flora Mae, divorced mother of two children, twice, and each time she appeared to be rather hostile and demanding. She finally said that "the other social worker", had promised her $20.00 a week, I asked her what she was earning. Flora Mae was working in the fields. She earned fifty dollars per five day week, or ten dollars per day. She planned to return to Florida about the middle of October and establish residence there. She was self-sufficient and made no specific requests other than to know why she did not get her $20.00 checks. I told her possibly the other social worker had hoped to get her public assistance because she had communicated with many authorities but had been turned down by all. Possibly, they thought she did not need assistance.

At a time when she had said that she was not working in the fields, the nurses had seen her working on each of their visits. She told me she had been working most of the summer "when there was work, at least three days a week." Although she earned up to fifty dollars a week and was self-sufficient, I don't think she wanted anything of social service other than the "twenty dollar check".

"Camile"

Case was phoned in by Dr. M. because Camile had a large umbilical hernia. Since no nurse was available at the time, I visited the farm. Child is youngest of eight children....mother deceased. Camile lives on farm with three siblings and her aunt, Mrs. H. They have residence, and Mrs. H. gets ADC for three of the children.

I called ADC (Mr. E.'s office) for verification. Case transferred to Miss W. to make above information available to her.

Contacts: 1 visit to farm to see patient and "guardian"
1 phone call - Dr. M.
1 phone call - ADC

"JET HENRY"

Case referred by a County Health Coordinator, more for information than anything else. Basically, he wanted to know who would pay for medication for "Jet Henry" who is a TB patient, recently discharged from a Florida Sanitarium. State policy was interpreted to him from Trenton, and I visited him to discuss our possible availability in this situation. He felt we were not needed and would call us if he thought we were.

Contacts: 1 visit to Dr. D.

"M. FAMILY"

Referral made because family of ten supposedly needed housing. Family known to Health Department in previous years. I contacted Public Health Nurse in Cumberland County when I could not find the family on the farm where they had been reportedly living. The Public Health Nurse knew the family well. She said they had left the area voluntarily. She emphasized that they often exaggerated their situation to get sympathy. Father P. verified this. Case closed.

Visits: 1 to farm
2 to Collaterals

"CAROL"

This case points up strongly the need for immediate referral. On July 30, Dr. J. informed Public Health Nurse that Carol, a 10 year old Negro Child, was diagnosed as having sickle cell anemia and a brain tumor which was causing progressive paralysis of the right side.

The case was referred to us on August 4 and I immediately went to the labor camp with a Public Health Nurse. We were told the family had returned to Florida the previous day. The New Jersey Department of Health alerted the Florida Department of Health as to Carol's condition and probable destination in order for her to be seen there.

"RAMON"

Ramon was first seen by a Public Health Nurse to whom he appeared listless, underfed and ill. He appeared jaundiced, did not retain food and appeared to have a serious health problem. The mother was upset because he could not or would not eat. She was trying to feed him raw eggs because in Puerto Rico, she had heard this was healthy.

He was admitted to Childrens' Hospital in Philadelphia on May 25, 1964 under Dr. C.'s program. I took Ramon and his mother in the Mobile Unit. Mrs. H. went along as interpreter. Admission was facilitated by Mrs. S. of Social Service, but a long wait was encountered before the Spanish-speaking resident took the history. The trip took the better part of a day, and was expensive from the point of view of cost per hour. Personal contacts with the hospital staff regarding Ramon's condition were had daily. A nucleous of PTA members formed a group who took the mother to see the baby four times and also gave transportation to take baby home on June 23, 1964, the day of discharge.

By discharge time, Ramon's diet had been regulated and he was retaining food. The presumptive diagnosis was "infectious hepatitis". Since this situation involved primarily follow-up of hospital instructions upon his discharge from the hospital, the case was transferred to the nursing department.

Impressions and Suggestions:

In this situation, the farmer's wife, Mrs. S. was very sympathetic and interested in the baby's condition and welfare. She had even learned Spanish well enough to converse with her employees. However, where such a person is not available, an interpreter should accompany the nurse on the first post-discharge visit when the hospital instructions have to be explained and demonstrated to the family, since either misinterpretation or misunderstanding could be dangerous, too much so to be considered a calculated risk.

The Mobile Unit will be made available for a volunteer to drive, and the actual process of admission can be pre-arranged with hospital social service, thus freeing a professional social worker or other paid employees of the Department for other duties.

"RICHARD and WILLIAM"

This case was referred by a Public Health Nurse to whom farmer had complained that Richard and William, ages four and five respectively, had been left in his all male labor camp by the mother on a Friday and were still there on Monday morning.

Visit to farmer and to camp verified the report. The crew leader and several workers reported mother had gone off with a worker whom the farmer had fired immediately.

I reported the situation to Mr. S., District Supervisor, Bridgeton Office, Bureau of Children's Services, and requested that a caseworker be sent down as soon as possible. Mrs. C. of that Office arrived within an hour and a joint visit to the camp revealed the children to be without shoes or clothing other than the outdoor shorts they wore. Evidently, the mother had brought them there often, as there was an outdoor metal swing set up for them. They refused to get into my car or Mrs. C.'s. I paid one of the workers whom they trusted for his gasoline and time lost from work and he drove them to the Bridgeton Office of the Bureau of Children's Services. I signed the request for their intervention in the case. The boys were fed, and new clothing was to be bought for them as soon as they were taken to the foster home which had been picked for them.

Since the boys did not appear to be neglected, and such a charge would be more difficult to prove, they were accepted as abandoned children.

Upon my return from Bridgeton, I found the mother in my office demanding her children. She was accompanied by her current "boy friend". She was referred to Bridgeton. They have reported that the children will remain in the foster home until the mother can provide an adequate home for them, and it is doubtful that she can do this as she reportedly goes from labor camp to labor camp and is, as the farmer described her, "the biggest prostitute in Salem". This case was opened and closed during one working day. Transfer of case to Bureau of Children's Services precluded our further participation in the case.

Contacts: Mr. F., farmer; crew leader; migrant worker;
Mr. S. and Mrs. C., Bureau of Children's Services; Mr. H., Interpreter.

"BARBARA"

I made two visits to this camp with a Public Health Nurse who referred case. Patient had said I must come with the Public Health Nurse if patient is to talk with me. Patient is southern white woman, age 23, living with Mr. M. after having been deserted by her husband. She has two children by husband and is now pregnant by Mr. M. She claims Mr. M. is sending her back to Florida because he thinks she is unfaithful. She claims he brought a friend home who later said she slept with him. She insists this is not so and that the friend was a "plant"....just an excuse to get rid of her. Her greatest concern is what will happen to her when she gets to Florida as she has no money.

Her mother lives in a low rent housing project in West Palm Beach, but she doubts she can stay there. On the other hand, she said she wanted to go to Florida and had saved up money for her plane tickets. Her mood did not match her concern. She gave permission for me to use our chain of service for information and arrangements were made for the Public Health Nurse and me to return on the following day. Our Cooperating Representative for West Palm Beach is the County Welfare Department. They informed me that they know Barbara well, and also her mother. Both have received financial assistance. Barbara "had made herself unwelcome in the housing project by her misconduct". They spoke with her mother who promised to put her up "for a while". They informed me that since she broke her residence, she cannot get financial assistance from them, and since she broke her state settlement (5 consecutive years) she cannot get ADC. She could get temporary help from the Salvation Army. When we went back the next day to talk with her, Mr. M. met us in front of the house and told us she had left early that morning for Florida by bus. He had driven her to Philadelphia. I notified the Welfare Department in West Palm Beach. They will try to see her. Possibly they can help her "through the back door by getting her to prenatal clinic".

"WILLIE"

Referral made by Rev. S., Negro Minister, in whose home Willie was staying. Willie had been discharged from the Bordentown Reformatory where he claimed he had served a four year sentence for "non-support". He supposedly had found his girl friend, (mother of his child) in bed with another man, and had run out on her. She supposedly had him arrested for non-support. Actually, he was arrested for assault and battery. He worked at farming at Bordentown and professed a great love for it.

Rev. S. had gotten him a job at the J. Farm. On payday, the other workers wanted him to go into town to get drunk. He refused and got into a fight, and fearing further trouble, left the farm. He had not reported his change of address to his parole officer.

With his permission, I called the parole office in Camden. They seemed to know Willie quite well and were not concerned about his failure to report. A parole officer comes to Salem twice a week and will see Willie there. I also spoke with the Employment Service regarding employment possibilities for Willie and he was referred to the K. Farm, adjacent to the J. Farm. Several days later, Willie complained that the men from the J. Farm would come to the K. Farm and try to get him in a fight, so he left that farm also. I sent him to the Employment Service for a possible opening on a dairy farm or berry-picking in Atlantic County. I took him to a dairy in Pennsville, but the job had been filled, so he went to work in Atlantic County. Case closed on July 31.

Willie is a hostile, aggressive young man, with very little education and no special skills. He actually enjoyed prison...."I lived better there than any place else in my life." He could adjust best in a regimented, protective environment where his need to make decisions would be minimal and he would not have to worry about his three meals a day. He came to the office for five interviews, I saw Rev. S. three times at the office.

Other Contacts: F. - 1
H. - 2
D. Dairy - 1
Parole Office - 3
K. Farm - 1
Bordentown - 1

"ANGEL"

This case was referred by the Public Health Nurse who was called by the Clayton Police. Angel had insisted that his wife had been murdered by some men. The H.'s were called as interpreters. Nobody could be found, and Angel was remanded to Gloucester County Jail "for being unable to give a good account of himself". Actually, the Police recognized the fact that there was something mentally wrong with him and wanted to hold him pending an adequate plan. The New York T.A.S. was able to verify that the Angels had lived there for a long number of years; that there had been an application for A.D.C.; that Angel had been in Bellevue after attempting suicide; and that most of the addresses he had given were fictitious. I visited him in jail. Mr. H. went with me to interpret. He knew he was in jail, but did not know how long he had been there, how long he had been away from home, or what day of the week it was. He was also obviously trying to hide some knowledge of English. He said his wife had gone back to New York, but later questioning of the men at the F. Farm revealed that she had never been there; that he had been acting strangely; and that he had run off from the farm in his underwear.

The situation was discussed both with the Sheriff and Undersheriff several times and it was agreed that a 7 day committment to Ancora State Hospital would be arranged so that Ancora could get him back to Bellevue. This need was accentuated when T.A.S. in New York also reported that his stories of having been a patient and former employee at Mt. Sinai Hospital in New York could not be verified. Committment was effected as planned, and the information was phoned to the Social Service Department at Ancora. I was told that the Chief of Social Services, was on vacation and that the information would be given to whatever social worker would be assigned to the case. Information was also mailed in on the seventh day, I went to Ancora to bring Angel his suitcase. Mr. H. came along, should there be a need for an interpreter. I talked with a Spanish-speaking caseworker who told me that Angel's case had been staffed and that he had just been discharged. I wondered about the wisdom of that decision in view of the information I had given them. According to her, she had not been given this information, and refused to interrupt a staff conference to convey this material to the psychiatrist. She did, however, agree to try to keep Angel there until she could talk to his doctor about it.

When I got back to the office, there was a call from the Chief of the Service on which Angel was kept. He had called a meeting of the entire staff; Angel had been re-examined; a Spanish speaking psychiatrist had taken part in the examination; it was unanimously agreed that he was not psychotic; that he may have been suffering from a "Puerto Rican alcoholic syndrome"; and could not legitimately be held at the hospital. He said that Angel would be given shelter until the following day. He said Angel was returning to the F. Farm to finish out the season. Angel did not re-appear at the Farm and we have been unable to locate him.

"THE G. FAMILY"

This case examplifies both the treatment of emergencies and long term care as indicated in the early diagnostic contacts with the family.

Mr. G. was brought to the office by the farmer early in June. At that time, he had begun to "black out" in the fields. The farmer, who considered him the best worker that he had, was much concerned both for the man and the fact that he might lose a key worker. Mr. G. who was providing transportation for other workers from the labor camp to the farm, immediately stopped driving.

Arrangements were immediately made for Mr. G.'s admission to Salem Hospital. A study was to be made on the basis that this man had been injured while crossing a highway about seven years ago. He had been hit by an automobile while riding a bicycle; taken to a hospital where his obvious injuries were treated; a broken arm was set, a fracture in the leg reduced, and his ribs taped. No X-rays were taken. At Salem Hospital, at the time of admission, there was a question between the Chief of the Orthopedic Service and the Chief of the Medical Service as to which would admit Mr. G. The Chief of the Medical Service agreed to take Mr. G. A medical work-up indicated that Mr. G. was suffering from Grand Mal Epilepsy. It also indicated that he had suffered at one time a fractured skull and that there was some wire imbedded in the soft tissue of his jaw. The doctor implied in my conversation with him that there might be a direct relationship between the epilepsy and the skull fracture. Mr. G. was told that he could go back to work but was not to drive or operate machinery. He was put on Dilantin in order to prevent or minimize the seizures.

Since the Puerto Rican Home is patriarchal by culture, Mr. G.'s role in the family was reversed. His wife went to work in the fields and he watched the children. This was very frustrating to him. In order to change this situation, Mrs. G.'s sister, also a migrant, came from Long Island to stay with them. She would supervise the children, including her four-year old daughter, while Mr. G. went with his wife to work in the fields. Mr. G. was not able to work a full day. He tired easily and when this occurred, he would sit down and rest while his wife continued to work. This situation continued until the end of the season.

In the meantime, the G. Family had indicated to me their desire to leave the migrant stream. Their motivation to do this was very strong. Since the family had lived in this area for approximately the last eight years, there was little question as to where they would settle. Plans were made to refer them to the Rehabilitation Commission. The family would be eligible for A.D.C. They chose Camden as the City where they wanted to settle. By this time, Mrs. G.'s sister had become very much a part of the family, and they refused to exclude her from their plans. This meant finding a place to live in Camden for ten people and ultimately, a rather run-down 7 1/2 room row house was obtained. Some of the seemingly minor problems which this family encountered are worth nothing. Mr. G. had never seen either a furnace or coal before. Consequently, it was necessary to have a representative from the coal company show them how to operate the furnace. The danger of coal gas had to be explained to them. On one of my visits, I noticed that there was no bulb in the bathroom lighting fixture. When I asked why, Mr. G. explained to me that he took it out because the children would climb up and "fool around" with it. I had to point out that having no bulb in the fixture was much more dangerous than having one in the fixture since it was a shock hazard. On another occasion when I visited, one of the children came up to play with me and I asked why the child was home. Mrs. G. told me that the school nurse had sent her home because she had chicken pox. The symptoms of the sickness were unknown to Mrs. G. This was reported to the visiting nurse. These are some of the facets which we take for granted but which we can only become aware of during visits to the home. Still, they are important to both the health and even the lives of these people since many of them pose serious dangers from the point of view of accidents.

This family also provides an example for helping those who are strongly motivated to leave the migrant labor stream. Where planning is started early enough and where help is given early in the season with budgeting family resources and finances, a plan can be made to facilitate a family's leaving the stream. Where motivation seems strong enough and plans firm enough, a job or jobs can be located while the family is still working on the farms. The same is true of housing. The expenditure for furniture can be kept to a minimum through the cooperation of agencies if the family moves to a community where there is a choice of social agencies. I would say that the most important factors in effecting such a change are strong motivation on the part of the family and early planning.

"MARY T."

Mary is a 52 year old southern negro who was injured in an automobile accident. We were notified of this case a month later while she was still in the hospital encased in a body cast. The hospital was anxious to discharge her because there was no one to pay the bill. The municipality in which the farm where she had been working was located turned down her application for financial assistance. Mary remained in the hospital until the case was removed. For several weeks prior to her discharge, she was taught the use of crutches. When we were notified that the cast had been removed, a Negro foster home was located. In this home where the woman had been a practical nurse, Mary was given room and board. In exchange, she would pay part of the cost and she would act as a baby sitter for the family's two children. We are supplying financial assistance in the amount of $10.00 weekly until her application for public assistance is accepted or until a sister whom she mentioned is located. This type of foster care should be evaluated and used on a differential basis. An attorney was engaged on a contingency basis to investigate the circumstances of the accident and file claim with the Unsatified Claim and Judgment Fund Board. The automobile was registered in New Jersey and although uninsured, Mary's chances of collecting some money from the Fund are better than average.

"John H."

John H. was injured in an automobile accident on the third day he was in New Jersey. He was taken to a hospital where surgery was performed and we were told that he would be totally paralyzed from the neck down for the rest of his life.

John is a tall, slender, 36 year old Negro who has spent much of his life away from home. He has had an unsuccessful marriage and is separated from his wife.

John's surgeon is Dr. R. of Vineland, New Jersey. Dr. R. had suggested that John might be ready for discharge from six to eight weeks after surgery. This suggestion was made within one week after surgery.

There was considerable pressure from the hospital to have John removed as soon as possible. The Hospital Administrator had even suggested removal before the six to eight week period was up. The address that John had given upon admission to the hospital was never verified. However, through Mr. S., Executive Director of Family Services of Charleston County, Charleston, South Carolina, John's mother, Mrs. Beulah B. was located. She was desirous of having her son sent home as soon as possible. She has a daughter living with her and numerous relatives in the immediate vicinity. She thought she could take care of her son with the help of the public health nurses and the help of her daughter. Another son who had been shot by his wife had been taken care of by her and her daughter for a little over a year before he died. This son had been paralyzed from the waist down.

It was felt that without at least a public health nursing evaluation of the home, nothing could be done insofar as discharging John to his mother. Through Mr. S., this was initiated. At the same time, I spoke to the Director of the County Welfare Agency, and to the Director of the South Carolina State Rehabilitation Commission. In New Jersey, I spoke with Mr. H., Dr. B. and Dr. K. of the Kessler Rehabilitation Institute. Both Mr. H. and Dr. B. informed me that there are no free public facilities which could provide care for John in New Jersey. The people in Charleston, South Carolina informed me that they could not participate in any plan until they knew the exact nature of his injuries, his present condition, and prognosis. Consequently, Dr. K. made a week-end trip to examine the patient. In essence, he did not see much room for improvement though there was still "life" in a few of the hand muscles and it was his opinion that with adequate rehabilitive care, some minimal use of John's hands could be regained. John would, however, need almost the same type of care as would an infant.

During this period, I was in constant contact with Mr. S. of Family Services, Mr. V., Administrator of the hospital, Dr. D. in Trenton and of course, the patient. John insisted that he wanted only to go home. With N.T.A.A. Funds, John's sister, Lorraine, came to Bridgeton. She was here while Dr. K. examined her brother. The problems in caring for him were explained to her but she felt that with the help of their family, he could be cared for. During her stay, Mr. S. phoned me with the information that John's mother had fallen and fractured her hip. This ruled out his home as a resource for his care. Shortly after the case was admitted to hospital, the administrator of the hospital was urged to have an application for assistance filed with the local municipality. He did not act upon this suggestion at that time. Later I assisted in processing an application for financial assistance from the Township of Upper Deerfield which was submitted to the Welfare Director, Mrs. C. The application was rejected. Mr. S. continued to "pressure" the authorities in Charleston, and upon receipt of Dr. K's report, the County Board of Welfare in Charleston agreed to accept responsibility for John's care if he was brought to his home. At this time, Mr. V. decided to talk once again with the Mayor of Upper Deerfield in regard to having the Township assume responsibility for John's hospitalization. John, by this time, had been in the hospital for three months. The Township was willing to pay the bill up to $10.00 a day and apply to the State Authorities for reimbursement of 80%. Upon communication with the State Authorities, they were informed that the State would not reimburse them retroactively. Consequently, the plan was dropped. The Township did furnish an ambulance, driver, attendant and a nurse to transport John to his home in Charleston. At that point, the County Welfare Organization in Charleston County, South Carolina, took over the case.

The driver of the automobile and John's crew leader were interviewed several times. Since the driver was not insured, an attorney was engaged to investigate John's chances of collecting some money from the Unsatisfied Claim and Judgment Board of New Jersey. We do not know what the possibility of collecting any money is at the present time.

CHAIN OF SERVICE

The Chain of Service was used in six cases for a total of twenty times. The San Juan T.A.S. was used in regard to one case involving verification of the need for the head of a family to return to Puerto Rico. In this situation, we furnished the cost of transportation. The New York T.A.S. was contacted twice in the case of "Angel." Two Florida Co-ops were contacted five times for two clients. The Family Service of Charleston County, Charleston, South Carolina, which is to become affiliated with Travelers Aid in January, 1965, cooperated with us in the case of "John H.", the quadruplegic. There were eleven telephone contacts with this Agency.

Each one of these cases amply demonstrated the value of the Chain of Service. In the case of "Barbara J." the Cooperating Representative is a Public Welfare Agency and although technically "Barbara" is not eligible for financial assistance, it was their feeling that something could be done for her since she would be going to their prenatal clinic. Verification of the information from San Juan was completed on the day following the original contact. Information from the New York T.A.S. was received on the days that the contacts were made. In one case, visits to a boy's family were necessary as were visits to an out-of-town hospital. Information was received on the day following each call. The Philadelphia T.A.S. cooperated in the purchase of a charity-rate ticket for a client in order for him to make a trip home. The value of the Chain of Service cannot and must not be under-estimated. To those in both the field of social work and other helping professions, it is a tangible tool which, through our contact, was made available to the Health Department. At times, Social Workers in other Departments and Agencies mentioned that many Family Agencies would cooperate on "Out-of-Town Inquiries". This is in no way comparable to the Chain of Service which is a concrete arrangement. It has been my experience during my practice of social case work that "OTI's" do not get prompt attention when they are received by busy social agencies. Every one of the Chain of Service Requests were attended immediately and even the one to San Juan, Puerto Rico was answered within twenty-four hours. This is a unique tool, one that is available to Travelers Aid and one that can be used in a most positive manner in describing our services and in our public relations.

FINANCIAL ASSISTANCE

Financial assistance during the first six months of the Project's operation was given in ten cases. The amount expended from N.T.A.A. Funds during this period was $1,048.47. The cases involved 27 people of whom eleven were children under the age of seven years. At least one-half of this amount was spent during the month of October and this money spent in October was used primarily to help the "G" Family when they left the migrant stream and settled in Camden. Emergency shelter for ten people had to be arranged while the house into which they were moving was made ready. They had no furniture and with the cooperation of Good Will Industries and several other such organizations in Camden, a minimum acceptable amount of furniture was obtained. Rent for the 7½ room row house was paid, coal was purchased and the utility bill was guaranteed. In the other cases involving financial assistance, transportation was furnished in four cases, spending money for hospital patients was furnished in three cases. The "G" Family was helped from the time in

June, when they applied, through the six-month period. The amount was increased when it became obvious that they would need clothing for the winter, and when Mrs. "G" was no longer able to work in the fields. Emergency money for food was given to one family whose new-born baby was to be brought from the hospital and the father would not receive his pay for a week. Miscellaneous small amounts were given to a client in jail, to a client who needed carfare to a job within the County and to a migrant worker to transport two children to the Bureau of Children's Services in Bridgeton when those children would not go with anyone from the Social Service Department.

The amount spent on financial assistance is in no way indicative of the need in the same way that the number of cases handled is in no way a measure of the potential number of cases which might have been referred to Social Service.

The average Puerto Rican is suspicious of anyone who offers him "something for nothing". A well educated non-migrant Puerto Rican, well acquainted with their culture, told me that they feel that Americans do nothing without the incentive for profit, consequently, culturally they would be suspicious of anyone who offered them assistance.

In four of the cases where financial assistance was given, in an amount above $10.00, the local Public Welfare Authorities were approached. In each case, we were turned down. In the case of the quadriplegic, however, we were offered by the Township the cost of transportation to get him home. At the end of the six-month period, plans were being formulated with the aid of the Family Service of Charleston County to get this plan into operation but with the goal of getting the patient rehabilitative care.

EVALUATION OF CASE WORK

Probably the stongest pattern visible at the present time is the one in which the case work practice of the Project is involved. It is the philosophy and practice of the Project that these cases be treated, whenever possible, as "short short term case work". If we are to work on this basis and accept this philosophy, it is possible to do only a little preventive case work. Many of these cases require a long term relationship. In view of the fact that there are no voluntary agencies in the area to carry these cases on a long term basis, if we are to meet this need, it will be necessary for us to work with these people at least as long as they are in our area and then help with a referral at their destination point when they leave here. There are two alternatives in accepting the "short short term case work" theory. First, it could mean helping a client from emergency to emergency and seeing the client only in times of emergency. This would keep the case work staff on the level of a fireman rushing to put out fires whenever they occur.

Second, it might imply a new concept in case work which excludes preventive measures entirely, that is, the migrant worker who comes to our attention wants us and needs us only in times of emergency. These alternatives would lead to the opening, closing and reopening of a case many times in one season whenever an emergency might occur. They would exclude completely the differential approach to case work. It is my opinion that with many families with whom we are in contact, a sustaining relationship throughout the season would help avoid many emergencies which might crop up were we to handle them on the "short short term case work" basis. I think that much insight that we get in working with these people will come primarily from a sustained relationship with them. I do not rule out the emergency cases which can be handled in a very short period of time and then closed, but I do object to a policy of handling all cases on a short term basis because it is costly to the Project and costly to those people whom we try to help, who need and may be denied a long term relationship with a social agency. Our services should be made to suit the needs of the clients rather than the clients molded to suit our services.

At the present time, when the "battered child syndrome" is becoming a topic of marked interest and attention in our field, it might be of interest to seek out such cases among the migrant families. It is my impression that even if we don't find physically battered children, we will find many emotionally deprived youngsters; children who have never had roots; who have never had security; and whose only hot meals come in the summer when they attend the migrant schools. It might also be of interest to work with the children on a comparative basis where some come from the close-knit Puerto Rican Family and others from the extended southern Negro Families, and try to ascertain whether problems and behavior are similar or noticably different under similar circumstances. Whether these children grow up to remain in the migrant stream or whether they leave it is not important. How they cope with their problems in a society which might be strange to them and which has rejected them as children is very important. Their current behavior in the migrant school might also be observed. Activities in which they are involved could form the background for adequate professional observation of these children so that on the basis of their behavior some prognosis might be made for their future. It is important to determine the effects on a child when the father, in a strongly patriarchal family, is away from home at least six months of the year; where children are left behind while the parents work in the migrant stream, it is important to determine the effects upon them of the parents' absence. We shall need the cooperation of our counterparts in Puerto Rico and Florida to study these important questions.

Although academic education is of prime importance and ranks high among the unmet needs of the migrant workers, there are other practical educational needs which must be met. For example, many of the Puerto Rican workers are afraid of savings banks and either carry their savings with them or leave them with a storekeeper or someone else for safe keeping. The value of the savings bank must be made clear to them for their own protection. The problem of driving without a license is a serious one and yet this is probably the most common cause for the arrest of the migrant worker, especially the Puerto Rican. Many have been arrested more than once for this offense. They must be taught that it is a serious offense. In this regard, they must also be taught that in order to be a safe driver, they must be literate at least to the point of being able to read road signs, otherwise, accidents are inevitable.

I have been told by the Puerto Rican Social Worker that "on the Island" mistrust of attorneys is common and that many clients go from attorney to attorney almost on a "shopping" level. In South Jersey where plans are being worked out for free legal help for the migrant worker, the plan is endangered should they follow the cultural pattern prevalent in Puerto Rico. Consequently, education in this area is important if the free legal help is to continue to remain available to them.

In an area where there are small lakes, irrigation ditches and small streams and in an area where the summer is hot and humid, workers often go for a swim. My conversation with many of the Puerto Rican laborers as well as the southern Negro workers lead me to believe that most of them cannot swim. Possible tragedy could be avoided if it were possible to obtain facilities for swimming lessons even on a limited basis.

During my conversations with many workers, they expressed a desire to be closer to religious services on Sunday. Although some workers actually work on weekends, many, especially the women, children, are available for religious services. Some who have cars don't bother to go because of inertia. However, if plans could be arranged with some of the churches to send school buses to some of the larger camps and the smaller ones on the way to pick up people to take them to religious services, I think that a better climate might be established in many of the labor camps in the tri-county area.

Insofar as case work services are concerned, it is especially important to interpret to the other disciplines in the Project area what our functions are. It is necessary to maintain adequate lines of communication between the various disciplines. It is necessary for the social workers to understand the work of the health educators, the nurses, public welfare directors and hospital administrators. Case conferences should involve those members of all disciplines who are working with the same case. Case conferences on a broader basis involving all the members of the Project might be held once a month or as time allows. It is futile however, to allow each discipline to "work in a vacuum" and expect to have a unified Project and a total patient rather than a segmented one.

VOLUNTEERS

This area is fertile territory for the development of a group of active volunteers. The nucleus can come possibly from the Parent-Teacher's Association. Mrs. Jay Nixon, President of the Salem County Parent-Teacher's Association was available whenever needed. It was she who maintained a group to furnish transportation for parents who wanted to visit their children in hospitals. Through her, the volunteer service can be enlarged.

Mrs. William Brill of the New Jersey Congress of Parent-Teacher's Associations lives in Gloucester County. I have had several conversations with her and she has offered her services whenever needed. I have also talked with Mrs. Brill about serving on our Advisory Committee and she has signified her willingness to do so. Mrs. Brill can be of great help to N.T.A.A. because she is involved in the State-wide work of the Parent-Teacher's Associations Congress and also because she is interested in N.T.A.A. and uses me as a "Consultant" on questions related to migrants.

In Salem County, the President of the Bar Association has agreed to assign members of the Bar to give free legal aid to indigent migrant workers. If this aid involves a law suit for damages, the case will be assigned either on a contingency basis or on a fee basis determined by the Judge. Where the case is lost, no fee will be involved. I have been working to establish this plan in Cumberland County but as of the end of the six-month period, I have only been able to get individual attorneys to agree to furnish legal assistance in this manner. I have not yet been able to get the Bar Association to accept this plan. In Gloucester County, free legal aid which technically is furnished by the County itself, can be assured if the Dean of the Rutgers Law School at Rutgers in Camden is contacted.

During part of the summer, a volunteer sent by the Mid-Atlantic Region, Y W C A, worked in the Woodstown Office. She could not complete her tour of duty because of unforseen financial problems within their project. It is my opinion that if volunteers from other parts of the Country can be brought into New Jersey to work with the Agricultural Migrant, there should be an attempt to interest teen-age volunteers from New Jersey to work with the Agricultural Migrant within their own state. Such a program should be discussed and planned early in the season in order that its full effectiveness might be realized. Such a program might include only a small number of volunteers for the coming season. If it is successful, I think it would "mushroom" throughout the State.

During the coming season, I hope to be able to devote more time to a volunteer program. The effectiveness of such a program lies in our ability to interest volunteers in the Program and show them just how much its effectiveness can be multiplied by their participation. I plan to start an Information and Direction Program early in the season. I had tried this during the past year but it was not accepted with any degree of enthusiasm primarily because it was too late in the season. This fact points up the necessity for advance planning for contemplated activities wherever possible.

MOBILE UNIT

The Mobile Unit is a Dodge A-100 "Wagon". It was one of the early ones to come off the assembly line and consequently, had many "bugs" which have been repaired. Aside from the "bugs", the major expense has been for snow tires. The other repairs have all been free since the Dodge People give a 50,000 mile guarantee.

There has been a misconception among a number of people as to the function of the mobile unit. It has been called a mobile health unit, a mobile dental unit and many other misnomers. Actually, it has given very adequate service not so much as an office on wheels but as a place in which a client can be interviewed with much more confidentiallity than in the labor camp or in the office in Woodstown. With the two back seats facing each other for this purpose and with the use of a clip board on which to write and take notes, interviewing can be accomplished with sufficient adequacy. There are two overhead lights so that interviewing at night is possible. It would be desirable to get some sort of a curtain or drape which can be drawn over the window so that more privacy during the interview can be gained. It seems to me that some of the clients felt very conspicuous when they got into the unit to discuss their problems.

In a Program such as this, the unit is a most valuable asset, not only for the reasons described above but also because it becomes a symbol of the Program. It is easily recognized. It carries with it an aura of gentle authority and in my experience has been welcomed wherever I have driven it.

COMMUNITY CONTACTS

Community contacts have been numerous and multi-purposed. Many have been through work shops sponsored by the Health Department or at staff meetings also sponsored by the Department. Among my individual contacts have been meetings with Mrs. Richard Zwemer of the Consumers League of New Jersey; Mrs. William Brill of the Congress of Parent-Teacher's Associations; Mr. Richard Moore; the Board of Directors of

Bridgeton Hospital; Miss Catherine Zimmerman, Executive Director Family Counselling Service of Camden; Dr. Livingston Cross, Glassboro State Teachers' College; Mrs. Jay Nixon, Salem County Parent-Teacher's Association; members of the Bar Association of Salem County and Cumberland County; the sheriffs and jail personnel of the tri-county area; Senator Harrison Williams, Jr. and Mr. Woody Price, his administrative assistant; Father James L. Vizzard, Catholic Migrant Labor Committee; Mrs. Lora Liss, Council of Jewish Women; personnel of the Commonwealth of Puerto Rico Staff; Dr. Frank Graham and A. Phillip Randolph of the National Advisory Committee on Farm Labor; George Norcross of the AFL*CIO Social Service Unit in Camden; Miss Paulsen of the Turrell Fund; and others too numerous to mention.

I have had many contacts with the United Fund Directors in Salem and Gloucester Counties and have met with the United Fund Director in Vineland. The Police Chief in Vineland and the Chief in Woodstown have offered their complete cooperation and would like to meet with us in the spring to establish a routine referral procedure.

In regard to the ultimate formation of an independent Travelers Aid, meetings were held in Trenton first with the Directors and Board Members of the Newark and Trenton Agencies and then with a state-wide group of interested parties. In South Jersey, I had met individually with a number of people for the purpose of ultimately forming an Advisory Committee for the N.T.A.A. Agricultural Migrant Project, keeping in mind that some of these people might later serve as Board Members of a permanent Agency or suggest names for Board Members. There are many more people to be contacted and this will be done as time allows after the first of the year.

EVALUATION

It is difficult to evaluate our participation in this program after only six months. It is even more difficult to make definite statements based on tangible evidence, since 43 cases do not provide a broad enough base for statistical and research purposes. I feel that we have not "scratched the surface". Potentially, every migrant coming to New Jersey might be a case for Social Service. Potentially, every prenatal case could be referred to Social Service. This means that aside from an aggressive case finding program on the part of the Social Service Department, aggressive interpretation of our services to the other disciplines is necessary. After this is done, referrals from the nurses and from the healtheducators, plus the results of our own enlarged case finding program, could triple or quadruple the case load.

There has been a friendly attitude on the part of the towns-people toward the Program. There should be a continuous flow of information to the local weekly newspapers in South Jersey regarding our services and accomplishments. Any antagonism toward the Program on the part of the towns-people is due to the fact that they did not know what we were doing or what our purposes were. I would like to see a statistical sheet on each case, the content of which we can discuss in Trenton, in order to have a running analysis of the cases which we are handling. Communication between the various disciplines must be improved.

The role of the interpreter becomes increasingly important as case records are either dictated or read. Ideally, the interpreter should have as good a knowledge of English as he does of Spanish. Ideally, the interpreter's orientation should be such that he will transmit to the client only what the social worker says or asks, and transmit to the social worker only what the client answers or asks. If the interpreter's knowledge of Spanish is much greater than his knowledge of English, something is lost in the transmittal of information between the case worker and client, and vice versa. Very often, inadequate interpretation leads to misunderstandings between the clients and the social workers.

A STUDY OF THE ATTITUDES OF MIGRANT WORKERS

NEW JERSEY 1964

The industry of fruit and vegetable production in South Central and Southern New Jersey is largely dependent upon migrant labor. These laborers are mainly native to Puerto Rico and Southern on-shore states. In 1963 there were 21,871* in New Jersey. 10,665 of these lived in 1,121 migrant labor camps on the farms of Salem, Gloucester, and Cumberland Counties, 8,835 were from Puerto Rico and 1,605 were American Negroes mainly from the southern states.

The mobility of the migrant agricultural worker increases the severity of public health and social welfare problems commonly found in low income, unskilled labor groups. Continuous change of environment multiplies health and social welfare hazards. They have no legal settlement. Their rights are hidden. Local health and welfare resources at various stopping places as they travel "upstream" are unknown. At times, they too seem to be purposely hidden. Native cultural patterns become a problem instead of a protection.

In 1963 Congress passed the Migrant Health Act to help provide and improve services to migrant workers and their families. In 1963 a Grant was made by the U.S. Public Health Service to the New Jersey State Department of Health. This grant is administered by the Division of Preventable Diseases, and its Migrant Health Program.

THE ASSIGNMENT

The grant provided for a health educator with the specific assignments of:

1. development of a plan for survey of selected groups of migrant workers to determine
    - a. their level of awareness of personal health problems and the available health facilities.
    - b. their attitudes towards personal health problems and the available health facilities.
    - c. their practices with regard to personal health problems and the use of health facilities.

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*1963 statistical report New Jersey Department of Labor and Industry, Bureau of Migrant Labor.

This activity will include:

1. A review of current literature.
2. Preparation of an interview schedule and selection of a study population.
3. Selection and training of interviewees, public health nurses, medical students, or volunteers.
4. Supervision of the interview procedures and results.
5. Arrange for tabulation of data.
6. Analysis of findings, preparation of a written report.

RECRUITMENT OF STAFF

A health education staff was recruited, and started to work during the month of June 1964. The staff included:

Consultant, Community Health Organization

Consultant, Community Health Organization from Department of Public Health, Commonwealth of Puerto Rico

Student, USPHS, COSTEP, undergraduate student, University of North Carolina

Student, undergraduate, Lincoln University

The efforts of the newly formed staff were aided by consultation and guidance provided by the Consultant Community Health Organization, in the Vaccination Assistance Program. Experience gained in that Program was translated to the Migrant Health Program Activities to assist in advancing immunization of migrants. The face-to-face contact so valuable in dealing with hard to reach groups is doubly valuable in this Migrant Health Field.

The State Consultant, Community Health Organization served as Health Education consultant to the Migrant Health Education staff.

All staff members were without knowledge of or experience with the migrant agricultural worker and his problems, the migrant health service, and none had direct experience with survey and research techniques. This situation was advantageous for the creation and practice of group thinking and action on the part of the staff. Each member of the staff was involved in the solution of the problem; we all started without specific equipment for the situation. This helped develop group thinking and group responsibility.

After three days of reading the group exerted considerable pressure for a visit to a place where migrant agricultural workers were employed, and where we would work this summer. As a result we visited a large farm and were able to sit in on a first hand interview between the consultant and the farm foreman. This experience made reference reading more meaningful. One of the lighter sides of the expedition to the farm was that no one in the car could identify the vegetable that the migrant workers were picking as we drove along the road. Later it was identified as asparagus.

Among the references used for staff orientation were:

1. "Health Services for Migrant Agricultural Workers in New Jersey, 1963".
2. "On the Season", Florida State Board of Health, by R.H. Browning and T. T. Northcutt, Jr.
3. "Proceedings of Conference on Migrant Health Education Materials", January 1964 at the Department of Public Health Education, School of Public Health, University of North Carolina.
4. "They Follow the Sun", E. L. Koos.
5. "Health and Medical Services for Agricultural, Seasonal Workers".
6. "Education of the Adult Migrant".
7. "Migrant Health Education Materials".
8. "Selected State Programs in Migrant Education".
9. "Health Project for Migrant Farm Families, California's Experience," by Lawrence Wyckoff.
10. Migrant Labor Act, Chapter 71 P. L. 1945, Department of Labor and Industry.
11. "Crew Leaders Hand Book", New Jersey Department of Labor and Industry, Division of Migrant Labor.
12. "1963, Statistics, Bureau of Migrant Labor, New Jersey Department of Labor and Industry.
13. "Migrant Health Act, Progress Report", November 6, 1963, U.S. Department of Health, Education and Welfare Public Health Service.

SURVEY QUESTIONNAIRE CONSTRUCTION

To compile the questionnaire, extensive reading on migrant health programs elsewhere and conferences with staff and that of community agencies was necessary. Group discussions and conferences on wording, choice of question and subject matter would sometimes break up early in the day in order to consult our resources, or they might last well past closing hour. Questions were designed to bring out attitudes on being a migrant, health knowledge, attitudes and practices. Group thinking developed. Revision of parts of the questionnaire were commonplace.

Three revisions were made in the questionnaire compiled. The first of these was after the pre-test of the questionnaire on interviews with 9 migrant agricultural workers from several different farms. The second revision was after the first two consultations with Dr. Richard Stevenson of the Department of Economics and Sociology, Douglass College, New Brunswick, New Jersey.

The consultation with Dr. Stevenson improved the structure of the questionnaire and he advised some revisions on wording. Most of all, this consultation promoted staff assurance.

SELECTION OF SAMPLE FOR TESTING

Every tenth card was pulled from the 1963 file of farm owners in Gloucester, Salem, and Cumberland Counties who employed migrant labor and were known to the migrant nursing service in 1963. A sample of 129 farms resulted. Telephone calls to these 129 farms resulted in a mortality of 50 farms on the list. The reason for the greatest fall-out was that no migrant labor was employed on the farm in 1964. Second to this reason was in inability to identify the telephone number by the address given, no listing, or no answer after many attempts to telephone the farm owner. As 100 farms was the goal of the group for the Sample, a second sampling was made. As the mortality of the initial sampling was well divided among the three Counties, an additional 15 farms from each of the three counties was decided upon. The method used was to divide the number of farms in the files for each county by 15, and the frequency pulled according to the results, i.e., as there were 340 farms in the files for Salem County, every 23rd card was pulled for a sample of 15.

PROCEDURE OF TELEPHONE INTERVIEW

The telephone numbers of the 174 farm cards selected were identified; or identification was attempted. Those not readily obtained were sought from nursing records, telephone information service, and in some instances other members of the family who lived near by. The differences in mail address and road address, sometimes crossing county lines, which meant a different telephone directory, added to the problem. Some farms had no telephone listed under the owner's name, but the name of the farm was listed. The purpose of the first contact by telephone was to ascertain:

a. If migrant agricultural labor was employed, or would be employed there in the current season.

b. The native language of the worker.

c. If we might call at a later date to arrange a definite day and time to talk to one or a few individual workers.

The second telephone contact was or was not made, in accordance with the information obtained on the first call. Travel directions were also reviewed with the farmer on the second telephone call.

There was a wide variety of response to both the first and the second telephone call.

The difference in reaction to our request to visit made a seemingly routine procedure of telephoning an art. A high degree of resourcefulness and sensitivity on the part of the staff member who was making the telephone call was helpful. It was made clear in all instances that we wished to visit the camp only on the worker's free time. This, in most instances, was after their supper, or Saturday and Sunday when they were most relaxed and free to talk. Noon visits on work days did not provide this climate permissiveness. The adjustment of the Health Department staff time to that of the farm schedule probably had a positive influence on the farm family's acceptance of the staff. During these telephone contacts with the farmers, their wives, and sometimes widowed mother, etc. who, one felt, still had authority, the need to create the appropriate impression and flexibility according to the first or second sentence of response, was frequently discussed informally among the staff members. More formal sessions on this were not held because of the complexities of the staff situation this first summer. They would be appropriate and should be held another time, particularly if non-professional public health staff is used.

Some farmer's wives seemed to feel quite secure in their husband's willingness to have stange health workers from an official agency with a connotation of authority talk to their migrant help. The other extreme was experienced, as many times with the need to "speak to my husband", the only information obtained. It was difficult to find out when to call some of the husbands, as the wives said, "he is in and out", and he probably was. A few wives said something like, "you do not have to wait until six o'clock, come at four, for health he will call them out of the field".

One wife said, "come along". Upon arrival her husband asked that we return two months later (October) as the workers were "too tired now".

CAMP VISITS FOR INTERVIEWING

The interviewing phase of the survey started on August 24. The visits were discontinued at the end of September when a total of 81 interviews and questionnaires were completed. Sixty-two of these were with migrant workers whose native language was Spanish, and nineteen English.

No worker refused to be interviewed. Sometimes seemingly from shyness, a worker would ask a friend over who proved to be more verbal. On these occasions every effort was made to continue to interview the first (shy) worker. Sometimes the more verbal worker would take over the interview and there was nothing to do but compile the questionnaire from the more verbal member.

The Health Educator from Puerto Rico had to conduct over 76 per cent of the interviews. He was assisted in these visits by the COSTEP student who made all telephone calls to the farms and made all personal contacts with the farmers where interviews were in Spanish. When the COSTEP student returned to school in September, the Staff Health Educator made the telephone contacts and arranged the visits and checked the travel directions. With the experience gained from visiting the farms with the COSTEP student, the Health Educator from Puerto Rico then carried out the arranged visits. The staff social worker from Puerto Rico made several interviews.

The interview activity itself was time consuming. It was not unusual to travel many miles racing the sun down the horizon in order to get interviews with two workers between the time when they would have had their evening meal, and darkness. Permission for several interviews with English speaking migrant workers came late in September, when the sun set earlier. They were far South in Cumberland County, and second interviews in the evening had to be completed in front of car lights or in cabins. On two or three farms mosquito bites averaged at least 30 per questionnaire.

The migrant workers no doubt found the questionnaire interview a strange experience. Consider the question, "Some people think the work you do is very important. Do you think so"? The intent of the question was felt to be important enough to include it. Within the context of the situation, an on-the-spot answer to this and some of the other questions was asking quite a little of the workers. Verbalization of this kind of information may be quite new to many. We were strangers, different and perhaps in some ways like an authoritative figure. There was no way to prepare the individual worker for the interview before it took place, or to send him advance information that he would be asked to answer many questions by the health worker. It was not possible to select people to interview according to a formula. Once one was in a camp, one became an opportunist, and bearing in mind broad outlines observing proportion of male to female, etc.; one interviewed the workers who were there at the time and not actively engaged in other activities.

In spite of its strangeness, some rapport was established in varied degrees. The questionnaire was long for some workers. When there was any indication of a lack of interest, the material on the interview schedule was forgotten and a switch to conversation of more probable interests was made. Later attention was returned to the schedule form.

A memorable experience involved two middle aged women who were interviewed on the concrete steps of a cabin at nightfall in southern Cumberland County. Both women had no dependents, their children were married and out of the home. Their husbands were not in the picture. Each owned a trailer in Florida to which she returned every winter. They came to New Jersey to "earn a little tax cash" and because it was cooler, and their friends and neighbors came. Also, there was less "maid work" in Florida in the summer. The first woman interviewed did not comprehend the questions on medical care. When the second worker was asked the same questions on medical care she made it clear that they believed that the church elder was the person to give advice on illness. She said, "I go to the Elder and then I go to the doctor". During this interview a worker was obviously scrubbing down a cabin just vacated. The two women were absorbed in watching this procedure, and commented upon the fact that it was unusual to have such thorough cleaning done by "him". The man was a crew leader, and what she did not know, and I did not tell her, was that there was a crew leader's health meeting held the evening before by the County Health Officer on sanitation, and this man had been present. One of the two women said to the other, "I am glad to see this".

On another visit to another farm, the crew leader took over the time allotted to the questionnaire interview to discuss the same crew leader's meeting. He remembered seeing the interviewer there. This crew leader also asked why it made his workers sick to travel. Nausea, vomiting and diarrhea among the group is a usual occurrance after each trip. Hygenic practices during the trip were discussed with emphasis on hand washing after toilet and before eating. It was learned that cold cuts of meat are purchased along the way and that the practice of "we try to give them one hot meal" suggests many opportunities for food contamination, particularly as they have no refrigeration for the cold cuts.

THE OBJECTIVES OF THE SURVEY ACTIVITY

1. To obtain information to develop a health education program based upon the migrant health needs and interests.

2. To assist the staff to develop methods of education whereby the migrant agricultural worker and his family will perceive the health content to an extent which will motivate them to make the indicated changes in their health practices and attitudes.

3. To learn the place of good health in the migrant worker's standard of values.

4. To determine the attitudes and feelings of the migrant agricultural worker toward the permanent population in New Jersey, and if these affect his use of community resources.

The survey was also a major staff education project. The questionnaire enabled the development of group thinking and performance, self-motivation of the staff to seek general and specific information on habits, history, living patterns, sociologic and ethnic backgrounds as well as specific general health findings concerning the migrant agricultural worker. There was education of the staff on the composition of an interview schedule, use of the interview schedule, and the analysis of the information obtained. Activity connected with the questionnaire also gave geographic orientation to Gloucester, Cumberland, and Salem Counties where the migrant population was studied. It was an instrument to locate camps and learn how to reach them.

In addition to the specific information obtained from answers in the questionnaire, there were several other values to this activity.

Travel directions to individual camps and telephone numbers obtained are now a part of the written resources of the migrant health office. Camps new to the health service were located. The staff now has first hand knowledge of the physical conditions of a variety of camps. This should help in selective program planning, both with the workers, the farmers and other appropriate people. Workers learned to make telephone and personal contact with farm owners and their families in such a way as to establish good rapport with the individual involved. There was an effort toward the development of a positive relationship between the staff of the Department of Health, and the farm owner population. The establishment of a good relationship with crew leaders was initiated. This was improved by holding two crew leaders meetings to which they were all invited. The location of crew leaders and the assignment of the potential of each individual to implement the Department of Health Program Objective of service to migrant workers, should be of benefit. The experience helped the staff to develop and use methods and techniques to initiate and maintain a good relationship in these several areas of contact. We believe that the activity aided in the establishment of a good image of the Health Department to the individual worker, the crew leader and the farm owner.

RESULTS
PART I

The sample picked for the study of attitudes of migrant workers included eighty-one persons, 67 male and 14 female. Female workers comprise 17.3% of this sample. This is a higher proportion of females than are found in the migrant camps of Salem Gloucester and Cumberland Counties. According to the Bureau of Migrant Labor there are only 789 female migrant agricultural workers in these counties. This is approximately 7.4% of a maximum total of 10,665 workers housed there.

There are 62 Spanish speaking workers in the survey and 19 English speaking Southern Negroes. All of the Spanish speaking workers were born in Puerto Rico. Ten of the Southern Negroes came from the State of Georgia. The rest came from Florida, North Carolina, Alabama, Mississippi, Arkansas and Louisiana.

Two-thirds of this group were over 25 years of age. The age distribution of the men from Puerto Rico follows the age distribution of the total sample. The age of persons from the southern states tends to be slightly higher than the sample as a whole but the numbers are small and the pattern is scattered.

The 81 persons in the survey averaged 5.5 grade years of school per person. The English speaking group averaged 8.3 years/ person and the Spanish speaking group averaged 3.6 years. The older the worker, the less time he had spent in school. One worker indicated that he had finished four years of college. He presented an interesting profile as follows: This man likedbeing a migrant because he met different people. He disliked being a migrant because of the housing and living conditions. If he were boss he would change the scale of pay and housing conditions. He has worked at woodworking, carpentry and cooking in the past. He would be interested in being a tractor operator because it is better work and draws more pay. He entered the migrant stream because he liked farming and preferred it to caddying on a golf course. He preferred to go from farm to farm because he liked a change. He would not want his children to be migrant workers. If wages were increased he would not object if they wanted to be migrant workers, the children must decide for themselves what they are going to do. He left the camp on weekends to buy something in the town. On his time off he stayed with other workers. With the exception of his information concerning immunization his knowledge of health, symptoms of disease and signs of illness appeared to be more advanced than most workers.

Fifty-three of the workers had worked as migrants for more than 3 years; 43 of these men were over 25 years of age. Ten workers between the ages of 15 and 25 years had worked as migrants from 3 to 10 years. The majority of those between 15 and 25 years of age however, had been in the work two whole years or less.

Seventy-one migrants indicated that they had a permanent home, only 42% indicated that they owned the home.

The majority of the persons (73) in this survey gave their last address as either Puerto Rico or Florida. The remaining people came from Georgia, North Carolina, Virginia, Pennsylvania, Ohio and New York City.

Forty-three per cent of the persons interviewed came with crew leaders either from Florida or from Puerto Rico. Thirty-one workers indicated that they were not associated with a crew leader. Seven indicated that they were associated with crew leaders from New York or New Jersey. Several Spanish-speaking workers gave the winter address of their crew leader in Florida or in New Jersey and the address of another in New York. The relationship of the crew leader system to the Glassboro Service Association was not determined as the migrant's relationship to the Association was not questioned.

The majority of workers indicated that they had a Social Security Number. Most of them were able to give the number, others indicated that they had lost their number and thus were urged to request a duplicate card. One worker said that the farmer had her social security card. There seemed to be no correlation between the age of the worker and his possession of a card.

Fifty of the workers indicated that they had children ranging from 1 to 12 children per family. Thirty-nine per cent of the workers had from 1 to 3 children. While 50 persons claimed children as dependents, there were only 12 who had their children in New Jersey with them. These 12 people had a total of 38 children. Approximately 15% of the sample had children in New Jersey. This sample is exceptional for if it were true of all migrants, there would be 7,500 children of migrant families in the counties served by migrant workers. This is not the case, because previous counts in this State indicate a lesser number of children in association with the migrant stream.

In past years the question of possessing a birth certificate has been raised repeatedly. Sixty-one persons indicated that they had a birth certificate; 54 of the persons questioned were Spanish speaking, 7 were English speaking. It appears that a greater significance is attached to the possession of the birth certificate in the Spanish culture. Perhaps it is commonly known that Spanish speaking people must show evidence of the birth of their children in order to receive assistance. Fifty-one of the workers indicated that they were married. Their marriages varied in length from 6 months to over 20 years. The majority of persons had been married more than 5 years.

Twenty of the 51 workers who stated that they were married indicated that they did not possess a marriage certificate. It is significant that both partners understand the effect that lack of a marriage certificate may have upon Social Security benefits due the other partner or the children, particularly in the case of death of a working member of the family.

The Puerto Rican workers, were questioned specifically concerning their marriage occurring in a church. This provided a check upon marriage certificate information. The Professional staff from Puerto Rico indicated that if a person was married in church, one could be sure that there was a marriage certificate. Thirty-nine of the 62 Puerto Rican workers stated that they were married; only 13, one-third, indicated that they were married in church. This observation is important because in applying for assistance in New Jersey, it has come to light that the common law relationship, which exists among a number of Puerto Rican couples, is not accepted. Frequently they have been obliged to marry in a civil ceremony and obtain a valid marriage certificate before they are eligible for assistance.

RESULTS
PART II

The attitudes of the 81 migrant workers towards their work and total environment were assessed by a series of questions. The following analysis presents some of the most distinctive findings.

Nineteen of the men had been in the work one summer or less. Forty-nine of the workers or 60.5% had worked as migrants for more than two summers. Two of the workers proved to be year-round residents. One of them had formerly been a migrant. Thus, over one-half of the migrant workers were not newly aware of the conditions of work or living. They had returned over and over again.

When asked if they liked migrant agricultural work, 37 persons said they liked the finanical gain involved in migrant field work, 22 indicated that they liked the work itself. Thus, 59 persons or 72% said that they liked migrant agricultural work.

An interesting range of responses were elicited to the question; What do you dislike about migrant agricultural work? Fifteen of the 81 workers or 18.5% revealed no dislike for the work, an equal number said they disliked being away from their family. Twelve workers were unhappy with the housing and ten others indicated that they did not like the pay. Two of the workers said that the farmer did not treat them well, and others indicated a dislike for the climate.

It will be recalled that there were 37 workers who said they liked migrant work for the financial gains involved. These men were studied to discover their dislikes; 12 of these workers indicated that they did not like to be separated from their wife or family; 10 of these 12 men gave only this reason. Five workers disliked to do housework after a day's work in the fields and six others were unhappy with the housing. One man commented upon the lack of running water, no hot water and fights in the camp. In the course of this study, not one of the workers reversed his stand and voiced dissatisfaction with the pay.

Given the opportunity to modify the total environment of the camp, 32 workers indicated that they would modify two or more factors. This included pay, travel, housing, relationships with the employer, and working conditions. Fifty per cent of the workers indicated that they would change the housing situation. Another group, 31 in number, indicated that they would modify the pay scale.

In an earlier question, 18 persons had indicated that they were not satisfied with the pay or the amount of work. It is interesting to note that when given an opportunity to modify circumstances, that 31 persons would have increased the pay scale. In similar fashion, 12 persons indicated dissatisfaction with the housing, when given the opportunity to modify the housing circumstances, 46 persons would take affirmative action.

The 46 persons who indicated that they would change the housing if they were boss were studied to learn how long they had been in the migrant stream. Sixty-three per cent had been in the migrant stream for more than two years. Evidently one does not become accustomed to migrant housing as the workers know it. Specific comments made on housing related to hot water, toilet facilities, and better conditions within the housing unit. Outside toilets came in for comment not only because of their location but because they were not clean and because people were not careful in using them. Several of the workers indicated that they needed larger housing units with inside flush toilets. Comments concerning the bad condition of the cooking facilities and notations concerning the fact that the housing unit should be in accordance with the size of the family indicate that the migrant worker is perceptive of his environment, recognizes its deficiencies, and certainly would modify it if given a reasonable opportunity.

Fifteen workers had indicated previously no dislike for migrant agricultural work. Since there were 16 persons who would not change the environment, the 16 persons were studied to determine whether or not they were the workers who did not dislike the work. It is interesting to note that the 8 people found in this group gave as their reason an interest in traveling.

Migrants were asked if they thought that their work was important. This question was one which called for more time and thoughtful consideration than was provided in the interview. This issue was discussed in the introduction. The 69 affirmative answers might well be an agreement with what others thought rather than the persons' considered opinion. Work may have always been a problem for them and may have been considered a means of survival, thus most important to them. They probably never thought of harvesting in a broad analytic way as contributing to the health and welfare of the nation and its people. The workers may have feelings about the importance of work but they are not crystalized into thoughts which can be readily expressed. This is particularly true in response to strangers who appear on the scene unexpectedly and whom the migrant does not expect to see again.

An exploration of the frequency with which migrants had been involved in other forms of work indicated that 56 persons worked in other occupations; construction, building trades, factory work accounted for 36 of the affirmative responses. It is unfortunate that a deeper interview was not conducted to determine the background of the 25 persons who responded that they had never been involved in other types of occupations. All but one of these workers were Spanish-speaking.

The types of work which the migrant desired as an alternative included: working in packing houses, cotton farming, truck driving, operating a heavy machine, painting, cabinet making, repairing of television and radio sets. The man who mentioned radio and television repair had stayed in Bridgeton, New Jersey during the past winter for the first time. He had remained there without his mother, father, or younger siblings. During the winter, he had taken a course in tractor operation at the Bridgeton High School and in the current season he had received a raise in pay as a tractor operator. He was interested in reading and gave the impression that he might do other kinds of work well.

When given an opportunity to work in another occupation, 89% of the workers would make an affirmative choice. Sixty-two per cent of persons wished to work in a factory, the remaining answers involved five other occupations including: truck driving, clerical work, mechanic and building trades, and restaurant activity. In some instances the question was answered by "anything but farm work". There were nine persons who indicated that they would not be interested in any other kind of work. Five had never done any other kind of work, and thus had no base for comparison. Three of the workers had worked in a factory and had packed asparagus. One of these stated that he liked farming. The ninth person in this group had worked at a number of jobs requiring skill. He was found to have tuberculosis, and spent the winter of 1963-64 in a tuberculosis hospital in Florida. During the summer, he was under the care of the Bridgeton, New Jersey Chest Clinic. He did not think he should work at all. His attitude reflected the point of view, "Why should I be interested in other types of work?"

The 72 persons who were interested in other types of work, were asked: Why would you be interested in another kind of work? Forty-three of the 72 workers indicated that they preferred better conditions of work, a cleaner environment, "out of the sun", and a better scale of pay. There were 7 men who indicated that they liked the work that they had chosen, 4 were English-speaking migrants. All four had worked at other jobs. One who had been a plumber and carpenter wanted to be a short-run truck driver, another who had worked at a canning house wanted to pack sweet potatoes. A worker who had experience as a caretaker in a hotel, wanted to be a truck driver. A former construction worker wanted to be a brick layer.

The three Spanish-speaking migrant workers indicated their previous experience, one had done nothing but farm work, and desired to work in a factory because he was tired of farming. The second man had been in construction work and desired to be a carpenter. The third had worked in a factory and as a mason and carpenter. He liked the work in the factory because he had had experience there and knew how to operate the machines. Four of the men who gave no reason for the choice of work which they would desire to do, were English-speaking. They wanted to do clerical and office work. None had experience in the work that they had chosen. One of the girls who wanted to be a key-punch operator was the sister of a crew leader. She knew that it cost $700 for a course in Jacksonville, Florida. At the time she was interviewed, she was unmarried and had formerly done ironing for a living.

Forty-nine workers entered the migrant stream because they could not find other work or to make more money. These reasons are related to the need to survive. The other answers given by workers, reflect to some extent a choice based upon the enjoyment or pleasure of being a migrant worker, for example, accompanying a family or friend, adventure, travel and better living conditions.

Twenty-five persons who indicated previously that they had never done any other kind of work, were studied to determine how they entered in the migrant field. Nineteen entered because they were unemployed or they needed more money. It would appear that the workers who had no other experience entered the migrant stream to do the only kind of work they knew because they were unemployed, or because they had an opportunity to make more money than they previously earned. It is also probable that these workers felt that they had no other choice.

Three-quarters of the persons indicated that they would prefer to work and live in the same place all year round. Many of the workers thought it would help them to know people and the community in which they live much better. Twenty-four workers indicated they would like to live in the same place all year because they would obtain more money and it would be more economical. Nineteen workers preferred to live and work by going from farm to farm. The reasons they gave for their migrant way of life showed that they liked travel, and adventure, and that change afforded a better opportunity and a better location. The average age of the 19 persons who preferred to be migrant workers was 30.4 years, not significantly higher than the average for the sample as a whole. This indicates that age is not a factor in the preference of migrant versus the resident way of life. For these workers the wish to know the environment in which they work and live and the people who live in that environment is an important deciding factor in their choice of either the migrant or the primitive way of life. Some men settle down to know people around them more thoroughly, those who travel, want to know more places and more people. It is important, however, that the majority prefer to live and work in one place throughout the year. This indicates in many a desire for security and for stability.

Fifty-eight workers or 71.0 per cent did not want to see their children do migrant agricultural work. The majority indicated that the work was too hard the pay was not good. Many gave as reasons "they suffer, they get old". Five persons wanted their children to have more education for a better job.

There were 21 persons who indicated that they would like their children to be migrant workers. They gave as their reasons that the work was "good, not bad". They liked it. They indicated also that they wanted their children to have experience in different kinds of work. Others indicated that they would leave the choice to the children. One worker indicated it helps the worker and the country.

The workers were asked to consider whether or not they would desire their children to continue as migrant workers if the pay were improved. Approximately, one-quarter of the workers were willing for their children to be migrant workers if better wages were provided. Thirty-nine persons, however, voiced their unwillingness for their children to be migrant workers even with improved wages. Twenty-three people did not answer to this question. Their reluctance may indicate that the workers were considering the question that the important value for their children is not necessarily or exclusively money.

In a previous question, 58 persons indicated that they did not wish their children to continue in the migrant way of life. In another question, 39 persons indicated that they were unwilling for their children to continue in migrant activity even if the wages were improved. These persons were studied to determine whether or not their responses were consistent. Thirty-five persons were found who consistently indicated that regardless of conditions they did not wish their children to continue in migrant activity. It can be said that 43% of migrant workers have aspirations that their children will occupy a place in society better than they do.

The 39 persons who indicated that they wanted to see their children do another kind of work even if migrant wages were increased indicated their choice of future for their children. Fifteen chose professional careers, teaching, nursing, preaching, medicine, engineering and the arts. Fifteen others indicated that they wanted their children to work in skilled jobs. Those who gave miscellaneous answers indicated that they had not considered this choice because their children were too small, and others indicated that the children would have to decide for themselves.

Earlier, it was found that 55% of the migrant workers themselves preferred to work in a factory. The difference in goals for their children is clear and apparent. Whether this difference in goals is reflected in their plans for extra education of their children is not known.

The Departments of Education can materially assist migrant workers in achieving their ambitions for their children by helping them to understand how their children may progress through faithful attendance at school. In the schools where migrant children are taught, teachers themselves, must be imbued with a spirit of stimulating the ambition and assisting the children to develop their talents for the future.

Seventy-five of the workers indicated that they liked to leave their camps when they were not working. The majority of the men and women, had more than one choice of extra camp activity. Fifty-nine of the 75 workers said that they left the camp to go to stores, 28 left for purposes of recreation at the movies or a bar. Thirty-five individuals left primarily to satisfy their curiosity as evidenced by the expression, "looking around". Leaving the camp to shop is a necessity, "looking around" is the opposite and shows a real exploratory interest in the community people and places outside of the camp. Eleven of the 75 persons indicated that they had visited in Camden, New York and Philadelphia.

The frequency with which the migrant goes to store is interesting because it reinforces the impression that a substantial amount of the migrants' earnings are left in New Jersey communities.

In these responses, the migrant indicated a willingness to talk that was not evident in relation to other more serious questions, such as: his attitude toward earning a living, the life which he leads as a migrant, the life that he would wish for his children and his family.

The 75 persons, who left the camp when they were not working, described many different kinds of activity when they were away. Forty-one engaged in two to five activities. Their answers indicated that they bought supplies; drink, beer, and refreshments. It appears that there is a healthy trade with the community. The community benefits by their recreational activities outside of the camp. The full extent to which the migrant spends his wages in the community, is not known. This would be a desirable subject for study at some future time.

Sixty of the 81 workers leave the camp either on weekends or on the average of once a week. Relatively few leave the camp more than once in any week. It appears if one wished to, the best time to communicate with the migrant is during the working days and not on the weekends.

Over 90% of the migrants felt the farmers were glad to have them working on the farm, and that their work was important. Several spontaneous responses such as, "important to the farmer", "yes, because I make a living", give some indication of the migrants interpretation of importance. Some remarks made create some doubt that the answers to questions were not true.

Seventy-three of the 81 workers stated that the farmers treated them fairly. Remarks such as, "pay not enough", "could pay more", were listed alongside the response. These remarks are consistent with earlier attitudes that more pay is a desirable feature.

Most of the workers thought that their fellow workers treated them fairly. There were some who made the point that on occasion their fellow workers behaved badly, others objected to the fighting in the camps.

The majority of workers thought that the people in the town treated them fairly. Another added, "most of the time".

In contrast, only 52 of the 81 workers felt that they were treated fairly by the crew leader; 28 of the workers did not answer this question. One man said no. Some of the workers became vocal in response to this discussion.

Seventy-five workers said that they had never had trouble with the farmers, the people they work with or the people in the town. In regard to the crew leader, there were 10 persons in the group who did not answer the question. This creates the impression that the crew leader is not accepted as wholeheartedly as we might anticipate. From the point of view of Health Education it means that additional effort must be expended with the crew leaders for if he is to serve as a go-between, and to relay health information to the workers, he must be held in high respect. The people in the camp must turn to him on questions relating to health and to welfare.

Most of the workers spend their off-duty time with their family or fellow workers. They seem to be able to be able to discuss questions concerning spare time activities more readily and easily than the more fundamental questions relating to their livelihood and the welfare of their children, perhaps because questions concerning their children deal with their aspirations and they have not considered them as realistically as they have the realities of spare time and every day living.

RESULTS
PART III

Opinion among migrants was almost equally divided on the ill effects which traveling may have upon the health. Over half of the workers did not think that traveling would adversely affect their health. Over half of the workers did not think that traveling would affect the health of their family. Many may have responded because their family was not with them. Eight per cent of the workers felt that their children were healthy. The responses of the workers, however, raise a doubt concerning the migrant's understanding of the word "healthy".

A series of questions were presented to the workers that dealt with symptoms and signs indicative of personal illness or illness in members of their family. First, a great many of the migrant workers did not answer these questions, between 35 and 67 persons failed to answer. This finding certainly seems to indicate that an effort to acquaint migrant workers with the signs of serious illness must be made so that they may recognize illness and seek medical care.

Forty-one persons considered that lack of appetite was a symptom of illness. Thirty-seven persons said that fever meant illness. Twenty-nine individuals accepted cough as a sign of disease and 27 recognized pain as an important symptom. The physical signs of illness seemed to be less well recognized, 12 persons accepted loose bowels as a sign of illness, 10 persons accepted a lump or swelling as a sign of disease. It is interesting that "sadness, worry, quietness, bad humor", and inability to play were stated as symptoms of illness. In addition, signs indicating failing energy, weakness, fatigue, and sleepiness were also mentioned as important. These observations provide a clear guide to a major activity in health education.

After the workers had responded to the signs and symptoms of illness, either in a positive or negative way, they were then asked what they would do if they had experienced specific symptoms of signs. Forty-one of the 72 persons who answered the question indicated that they did not work when they had these symptoms. Answers varied considerably and there were five workers who said they were obliged to continue working. Workers frequently remarked that their answer depended on "how bad it was". If the symptoms were slight, they went to work. If they became severe they did not work. Only 7 persons mentioned a doctor as a resource. Since the question was definitely related, to whether or not they worked, this small number of answers relating to a physician means very little.

While tuberculosis has been discovered, with consistent frequency among the migrant workers, it is important to note that the symptoms and signs of this disease are poorly recognized by the workers. Sixty persons indicated only one symptom or sign indicative of this disease.

Cough seemed to be the most commonly recognized symptom. Only 2 persons mentioned the chest X-ray. There were many correct answers given including such things as weakness, loss of appetite, spitting of blood, expectoration of mucus, but most of these were mentioned only once.

Seventeen of the persons gave "big belly" as the predominant sign of having worms. Only one person said make a "stool examination".

Vomiting and pain in the stomach were accepted as the principal signs of food poisoning. Very few individuals mentioned diarrhea as an important manifestation.

Twenty-seven people indicated that pain in the abdomen or in the right side was indicative of appendicitis, 52 persons said they did not know the signs of this disease.

Sixty-two persons said they did not know the signs and symptoms of syphilis, 6 persons indicated that sores, blisters, and rashes as the signs of the disease.

Fifteen to 20 persons indicated that swelling and the presence of pus was an indication of an infected sore which might cause blood poisoning.

In general, the persons interviewed, did not have a ready answer to the questions dealing with symptoms of illness which are frequently found in migrant camps. Some of the lack of information was not expected. This was particularly true for the lack of positive answers concerning tuberculosis, because there has been a wide range of exposure to the popular chest X-ray bus in many parts of the country.

While food poisoning seemed to be a little more familiar to the migrant than other diseases, nevertheless, loose bowels was mentioned by only a few people. In the interviews, there was a lack of concern over this symptom when discussed in relation to all questions. This impression has been found by other professional workers in contact with the migrant workers. Symptoms of syphilis were given with even less frequency than other categories. The implications concerning health education may be resolved into the question: "Should one attempt to teach the migrants symptoms specific to disease or should symptoms which call for medical care, a physician's examination, a trip to the clinic be taught instead?"

An example of this approach would be to teach that rashes, vomiting, loose bowels, loss of weight, cough, etc., require that you see the doctor. When the migrant was asked what he would do about the various diseases, very positive answers were given in relationship to tuberculosis and syphilis. Practically all of the people would consult a physician for appendicitis, and many would seek the help of a doctor in the case of food poisoning. The positive responses to these diseases in relation to seeking the advice of a physician is outstanding. One wonders about a person's ability to respond when it would appear that he does not know of these diseases or suspect them. All of the workers interviewed indicated the kinds of sickness for which they would seek a physician. A number of the persons gave several different answers. The most frequent answer which occurred was, "Any illness, if bad enough". Other answers included: fever, pain, cancer, stomach-ache, headache, and cold. In general, the frequency with which these answers were given is quite small. While the response of the migrant appears to be quite definite in the presence of certain diseases, nevertheless, it is clear that he does not recognize the symptoms. When symptoms do occur, he does not recognize the specific symptoms but rather acts when he "feels bad" in general and seeks assistance earlier if the disease is "bad enough".

The principal medications kept by migrants to serve their needs are: aspirin, bay rum, Vicks Vapo-rub, alka-seltzer, and alcohol. There were 31 miscellaneous answers given to the question: "What kind of medicine do you keep?" These answers included quinine, cough drops, cough syrup, cough medicine, rattlesnake oil, anacin, to mention a few items.

Forty-two of the migrants indicated that they would ask a person other than a doctor for advice when they were ill. The greater number would turn to their mother. They would also turn to the drug man and there were six answers which included a witch doctor. One man said that he went to the witch doctor for nervousness and to a regular doctor for other kinds of illnesses. The nurse was mentioned only four times and a church elder was mentioned twice. Seventy-six of the workers indicated that if another member of their family were ill, they would take that person to a physician; 23 also indicated an adherence to home remedies.

Fifty-three persons indicated that members of their family had been in the hospital as a patient and 38 indicated that they themselves had been hospitalized. Sixty-four workers indicated that they were not afraid to go to the doctor as a patient and they were not afraid to go to the hospital, if they were ill. These questions show on the whole that there is not much fear on the part of the workers in connection with going to a doctor or hospital, in the case of illness. We do not know how these same questions would be answered in the general population.

The majority of workers agreed that the foods that they used helped to keep them healthy, strong and well. The answers to these questions were freely given with a great deal of talk similar to the answers given about the use of spare time. Again, the subject matter is familiar. It is not painful but pleasurable to discuss food and recreational activity. The same level of rapport is not observed in dealing with symptoms of disease and names of disease, with which the migrant is not thoroughly familiar and from which he takes no pleasure.

All of the workers had points of view on how to stay well. The most frequently enumerated methods included: washing of hands, sleeping, wearing of shoes, habits of eating foods, and cleanliness. There were also a variety of miscellaneous methods including "take epsom salts, take blood tests, do not drink rum, avoid drinking, take patent medicine, and physical exercise". Seventy-eight workers indicated that they believed that hand-washing after using the toilet was desirable in keeping them well. When asked why, 50 indicated that germs had something to do with their health. Germs were frequently mentioned through all of the interviews. It will be interesting to determine the migrant's idea of a germ. The majority of workers who believed that washing their hands after toilet was a helpful health practice indicated that they could carry out this practice. Eight persons said that they could not do so, 6 indicating lack of facilities as a reason. How the 72 who answered "yes" to handwashing after toilet, could accomplish this in many situations was not described. Toilet and handwashing facilities in the field where the harvest is conducted are known to be lacking. Camp inspection also revealed that handwashing facilities are not immediately available to privies and thus the validity of this answer is seriously questioned.

Most of the workers gave valid reasons for the presence of flies and rats about the home. Many mentioned food, improperly stored food, garbage, dirty cans, trash and junk. Others used terms such as unclean stuff, possibly to indicate food soiled dishes, and dirty floors. Throughout the discussions, there were comments that the flies and rats bring sickness and germs. Forty-five of the workers considered themselves well at the time of interview. There were many diverse illness and conditions given, including athlete's foot, kidney trouble, bad teeth, high blood pressure, mental disease, constipation, and symptoms preferable to the respiratory tract. When questioned about illnesses in their family, illnesses as diverse as those affecting the worker himself were specified.

A great deal of stress has been laid upon immunization as a means of protecting people from illness. Most of the people knew that they had been immunized against polio. Possibly, this has to do with the recent availability of the immunization and the method by which immunization is administered on a lump of sugar. Fourteen workers thought they had been immunized against tuberculosis. Immunizations were specified against 18 diseases including malaria, cancer, chicken pox, and yellow fever. In general, the workers had little information about protection against disease through immunization. They were most confused about tuberculosis probably because of the recent introduction of the Mantoux or Tine test. Thirty-five workers indicated that they had not received immunization. Seventy-three said they would go to a clinic to get immunization free. A lack of personal knowledge of immunization as a means of protecting health is serious. One wonders what diphtheria and smallpox mean to young adults. The lack of knowledge found indicated that a considerable amount of professional time must be spent in trying to explain to the workers the reasons why they are being immunized. Educational efforts to motivate persons to accept immunization must be subjected to objective analysis and discussion, by the professional disciplines of the Migrant Health Program.

Information which the migrant desired to assist him in staying well and helping his family to stay well, covered a wide range, but the most commonly sought information dealt with the kinds of food that kept them well and strong, care of their teeth, care of their eyes, and what one would call general health information.

It is interesting to note that two women referred to "all subjects covered by the elder". The elder referred to was also the crew leader. No opportunity presented to determine if he would be interested in scientific health information.

Sixty-nine workers had seen a doctor in the past 10 years; 47 had seen a doctor within one year. Most had sought the aid of a physician because of injuries or colds. There was no distinct pattern of illness among the workers. The majority of English-speaking workers said they had a regular doctor at home in the winter, 7 of the 19 did not have a regular physician. Seven of the 62 Spanish-speaking workers indicated that they had a regular physician while 52 of the workers did not have a regular physician. The difference in the two groups may reflect the difference in the pattern of medical care in Florida and Puerto Rico. While many of these people had seen a doctor within the past year, it is probably a case of seeing a physician to meet a need. Thirty-eight workers said that they go to a doctor for a check-up when they feel well, 17 indicated that they had received such an examination within the year.

It would have been of value to question these people in greater depth to determine: the extent of the examination; the laboratory tests given; the type of history taken; and where the examination or check-up done. It would be of value to know whether or not they sought a private physician or a public health clinic and who bore the expenses. One worker said that he went to get a blood test, another indicated that she went for a check-up after the birth of her child.

The regular health examination, in its best and broadest sense, is considered fundamental to the prevention of illness. Much research has been done on the best ways to provide this service. If we can accept that 47% of those interviewed really get a regular health examination when they feel well it will be helpful to know more of the particulars. It is felt that the concept of a regular health examination was not understood by the migrants and that this response reflected either a poor question or a desire to please. Eighty individuals indicated that they would attend a health movie in their camp and that they would discuss problems of their own in a question and answer period. They said that they would bring their friends and neighbors. They chose to know about health, tuberculosis, foods to keep them well and strong, care of eyes and teeth, and maternal mother's and infant's care. Practically all said that they would help to publicize a health movie in the camps.

SUMMARY

In the summer of 1964 the health education staff of the Migrant Health Program interviewed eighty-one persons in the Migrant Labor Camps of Gloucester, Salem and Cumberland Counties in New Jersey to determine health attitudes, knowledge and practices.

The sample had a higher proportion of women and American Negroes than was found in the migrant population of the three Counties in 1963.

Two-thirds of the group were over 25 years of age, the entire group averaged 5.5 grade years of school, more than half had been in work more than two years, 72% liked the work itself or the financial gain. If given the opportunity half the persons would change the housing, and over a third the pay scale.

Three-quarters of the persons had worked in other occupations. Over 3/4 of those interviewed wished to work in a factory, but 1/2 wished their children to have professional or skilled jobs. It is not known whether this difference in goals is reflected in their plans for their children's education.

The purchasing and recreational activities outside the camp reported by the workers reinforces the opinion that migrant workers wages help turn the wheels of the local economy. While almost all of the workers said they think the farmers, townspeople and their fellow workers treat them fairly, many did not respond when questioned in relation to the crew leaders.

Health knowledge on specific signs and symptoms of illness, symptoms of specific diseases and on immunization left much to be desired. The workers were best informed on polio immunization. While they said they would consult a physician for certain diseases, as a group they did not know the symptoms of the diseases. The amount of pain or discomfort or "how bad" are their criteria for consulting a physician.

Answers indicated that the majority possess basic information on fly and rat control and the desirability of handwashing to break the chain of gastro-intestinal infection. Other ways of keeping well were freely expressed with food, adequate sleep and wearing shoes well up on the list.

Almost all are interested in knowing more about health and would attend film and discussion meetings on their camp grounds in the evening.

PLAN OF ACTION

The findings of this survey should be made available to all persons and groups who are interested in them. Those groups concerned with migrant health, and those whose interest in migrant health is sought, should be given a definite opportunity to become acquainted with the information, and to discuss it. The information should be discussed this winter with: farmers, doctors, personnel of hospitals and welfare departments, local townspeople, local health and welfare agency personnel, the Migrant Labor Board and Bureau of Migrant Labor Inspectors. When feasible the findings should be discussed with the entire professional migrant health staff, crew leaders and migrant agricultural workers.

The need for a plan of action based on the findings of the survey is desirable to increase the understanding of those persons and organizations who have not been intimately concerned with the growth and development of the Migrant Health Program. The need for community groups to be involved in a plan of action is a pre-requisite.

It is recommended that:

The farmers in the three counties who employed migrant labor in the summer of 1964 be invited to a meeting this winter. A planning committee for this meeting would be desirable. It should include farmers, representatives of granges, the farm bureau, county agricultural agencies, and membership from the community. Each of these groups may be persuaded to hold a similar meeting, thus wide spread discussion may occur.

Presentations be made to organizations of townspeople, to include the findings of the Survey, the need for volunteer help and boarding places for students.

Attempts be made to reach physicians, hospital superintendents, welfare directors, and other professional groups in the three counties.

A meeting be organized with local county extension service workers and Rutgers Extension Service workers to acquaint them with the Migrant Health Program.

A presentation be made to the State Nurses Association in March.

The findings of the study be discussed at the next meeting of the Migrant Labor Board.

The study findings be presented to the camp inspectors of the Migrant Labor Bureau.

A planning meeting be held for the 1965 Migrant Health Service professional staff and nursing agency staffs in April.

A system of reporting daily arrivals of workers be developed and used in the Spring and early Summer and that meetings be arranged with the workers and the crew leaders with the farmer's help and interest, etc.

The method of interpretation of the findings of this survey to the several groups will be adjusted to their varied interests. The farmer may want information which will help him attract and hold his workers. The workers may be more interested in information on changes desired in the camp, recreation activities in the community, foods to "keep them well", health subjects and films. Each discussion session will provide an opportunity to bring other information to the attention of all groups. For example, the availability of schools and transportation can be discussed, and the workers can be advised about adequate education of their children if they desire them to be professionals and skilled workers.

The health information must be discussed with all professionals, particularly the public health nurses and health educators who have specific responsibilities for health. The social workers must discuss the findings on common law and other conjugal arrangements, particularly where children are involved.

These proposals for discussion do not mean that these professional groups are unaware of the situations described, rather that objective discussion will give rise to improved approaches and methods.

Health workers must discover what the word "diphtheria" means to the young adult migrant parent. It must be recognized that the word "shots" confuses people. Tests and treatments which are not protective are labelled "shots" and protective immunizations against certain diseases are described by the same word. An effort must be made to find the best words and methods for doctors and nurses to use in describing how well children or persons may avoid illness and disability due to some diseases.

Discussions involving this kind of exploration of subject matter will result in group thinking and action. Social workers will help reinforce education on immunization. Nurses and others will modify their approach to the couples who are not legally married but who have families.

The plan of action to implement this survey is to share the findings with persons who are interested, and to interest those who should be interested, and whose help is needed.

Action on the problems highlighted by these findings can in this way be formulated and guided by those upon whose participation successful action depends.

AGE, SEX DISTRIBUTION OF MIGRANT WORKERS
MIGRANT HEALTH ATTITUDE SURVEY
NEW JERSEY 1964

Age	Total	Male	Female
All	81	67	14
15-25	27	23	4
25-40	33	26	7
40+	21	18	3

PLACE OF BIRTH OF MIGRANT WORKERS
MIGRANT HEALTH ATTITUDE STUDY
NEW JERSEY 1964

AGE	TOTAL	P.R.	GA.	OTHER*	UNKNOWN
All	81	62	10	9	2
15-25	27	21	3	3	1
25-40	33	27	3	3	1
40+	21	14	4	3	

*** Florida, North Carolina, Alabama, Mississippi, Arkansas, Louisiana**

YEARS WORKED AS A MIGRANT
MIGRANT HEALTH ATTITUDE SURVEY
NEW JERSEY 1964

AGE	Total Persons	YEARS A MIGRANT					
		Under 1	1-2.9	3-5.9	6-10.9	11+	Not Migrant Now
All	81	13	13	15	25	13	2
15-25	27	7	9	7	3		1
25-40	33	3	3	4	15	7	1
40+	21	3	1	2	8	7	

YEARS OF EDUCATION COMPLETED BY MIGRANT WORKERS
MIGRANT HEALTH ATTITUDE SURVEY
NEW JERSEY 1964

AGE	Total Persons	YEARS OF EDUCATION				
		0-3.9	4-6.9	7-9.9	10-11.0	Over 12
All	81	29	20	18	13	1
15-25	27	5	7	8	7	
25-40	33	12	9	9	3	
40+	21	12	4	1	3	1

NUMBER OF MIGRANTS HAVING CHILDREN IN NEW JERSEY
MIGRANT HEALTH ATTITUDE SURVEY
NEW JERSEY 1964

NUMBER CHILDREN	NUMBER PERSONS HAVING CHILDREN	
	Total	In New Jersey
All	50	12
1	6	2
2	12	3
3	14	1
4	5	4
5	4	1
6	3	1
7+	6	

NUMBER MIGRANTS HAVING SOCIAL SECURITY NUMBER
MIGRANT HEALTH ATTITUDE SURVEY
NEW JERSEY 1964

Age	Total	Yes	No
15-24	27	25	2
25-40	33	29	4
40+	21	19	2
Total	81	73	8

"WHAT DO YOU LIKE ABOUT MIGRANT WORK?"
MIGRANT HEALTH ATTITUDE SURVEY
NEW JERSEY: 1964

NUMBER OF ANSWERS		1	2	3
NUMBER OF PERSONS	81	68	12	1
PERSON ANSWERS	95	68	24	3
FINANCIAL GAIN	37	29	7	1
WORK	22	17	4	1
NOTHING	9	9		
TRAVEL	7	4	3	
PEOPLE	6	2	4	
EVERYTHING	4	3	1	
COOLER WEATHER	4	1	2	1
MISCELLANEOUS	6	3	3	

"WHAT DO YOU DISLIKE ABOUT MIGRANT WORK?"
MIGRANT HEALTH ATTITUDE SURVEY
NEW JERSEY 1964

NUMBER OF ANSWERS		1	2	3
NUMBER OF PERSONS	81	64	16	1
PERSON ANSWERS	99	64	32	3
AWAY FROM FAMILY	15	10	5	
NO DISLIKE	15	15		
HOUSING	12	8	3	1
WORK	10	4	5	1
PAY	10	5	4	1
NOT ENOUGH WORK	8	7	1	
TRAVELING -	8	4	4	
HOUSEWORK-FIELDWORK	7	5	2	
MISCELLANEOUS	12	4	8	
NO ANSWER	2	2		

"As boss, what changes would you make?"

MIGRANT HEALTH ATTITUDE SURVEY
NEW JERSEY 1964

Number of Answers		1	2	3	4	5
Person Answers	125	49	56	15	0	5
No. of Persons	81	49	26	5	0	1
Housing	46	17	23	5		1
Pay	9	2	4	2		1
No Change	16	16				
Work Conditions	15	5	6	3		1
Traveling	9	2	4	2		1
Other	3	1	2			
Relation with employer	2		1			1
No Answer	3	3				

Persons who would change housing conditions by length of time in Migrant Work.

MIGRANT HEALTH ATTITUDE SURVEY
NEW JERSEY 1964

Length of time in Migrant Stream	Number of Persons	Percent of Total
	46	100.0
One year or less	9	19.0
One through two years	7	15.0
More than two years	29	63.0
Year around	1	2.0

"HAVE YOU EVER DONE OTHER WORK?"
MIGRANT HEALTH ATTITUDE SURVEY
NEW JERSEY 1964

NUMBER OF ANSWERS		1	2	3
NUMBER OF PERSONS	81	71	8	2
PERSON ANSWERS	93	46	16	6
NO OTHER	25	25		
CONSTRUCTION & BLDG. TRADES	19	12	5	2
FACTORY	17	13	3	1
RESTAURANT & FOOD TRADES	10	7	2	1
HOTEL & DOMESTIC WORK	9	7	2	
MISCELLANEOUS	13	7	4	2

"Would you be interested in other work?"

MIGRANT HEALTH ATTITUDE SURVEY
NEW JERSEY 1964

Number of Answers		1	2	3
Number of Persons	81	71	8	2
Person Answers	93	71	16	6
Factory	45	41	4	
Not Interested	9	9		
Building Trades	8	5	2	1
Truck Driver	6	2	3	1
Clerical	4	3		1
Mechanic	4	1	2	1
Restaurant	4	2	1	1
Miscellaneous	13	8	4	1

"Why are you interested in other work?"

MIGRANT HEALTH ATTITUDE SURVEY
NEW JERSEY 1964

Number of Answers		1	2
Number of Persons	72	61	10
Person Answers	82	61	20
Work, cleaner out of sun	25	19	6
Pay better	18	10	8
Easier work	9	8	1
All year work	7	4	3
"Likes" the work	7	6	1
Miscellaneous	9	7	2
No Reason	7	7	

"How did you get into migrant farm work?"

MIGRANT HEALTH ATTITUDE SURVEY
NEW JERSEY 1964

REASON	NUMBER PERSONS	PER CENT
Total	81	100
Could not find job	31	38.4
More Money	18	22.2
Accompany friend of family	8	9.9
Adventure, travel	7	8.7
Likes farming	6	7.4
Better living conditions	5	6.0
Miscellaneous	6	7.4

PREFERENCE OF MIGRANT IN RELATIONSHIP TO WORKING AND LIVING

MIGRANT HEALTH ATTITUDE SURVEY
NEW JERSEY 1964

		Work and Live			
	Total	From Farm to Farm		In Same Place	
Number of Answers		1	2	1	2
Number of Persons	81	15	4	56	6
Person Answers	91		8	56	12
Prefers to know place and people	37	4		27	6
More economical, more money	26		1	19	5
Change for a better location	7	4	3		
Likes travel, adventure	6		1		
Travels to work in summer	2		1	1	
Weather better	4	1	1	2	
No answer	2			2	
Miscellaneous	7		1	5	1

"WOULD YOU LIKE TO SEE YOUR CHILDREN DO THE SAME KIND OF WORK?"

MIGRANT HEALTH ATTITUDE SURVEY
NEW JERSEY 1964

		YES		NO			NO OPINION
Number of Answers		1	2	1	2	3	1
Number of Persons	81	21	1	49	8	1	1
Person Answers	92	21	2	49	16	3	1
Work too hard, suffer, get old	28			21	6	1	
Want them to have more education for better job	15			11	3	1	
Pay not good	11		1	6	3	1	
Wants them to have a better job	10			8	1	1	
Likes work itself, good, not bad	8	7	1				
So they can have experience and do different kind of work	7	7					
Miscellaneous, discuss	17	6		7	4		
No Answer	6	1		4			1

"With improved wages, would you still want your children to do other work?"

MIGRANT HEALTH ATTITUDE SURVEY
NEW JERSEY 1964

Answers	Number of Persons
All	81
Yes	39
No	19
No Answer	23

"What would you like to see them do?"

MIGRANT HEALTH ATTITUDE SURVEY
NEW JERSEY 1964

Number of Answers	Frequency of Answers Total	1	2
Number of Persons	39	30	9
Person Answers	48	30	18
Professional-teacher, nurse doctor, preacher, engineer, college, artist	15	10	5
Skilled and better job	15	8	7
Food and lodging	2	-	2
Factory	5	4	1
Miscellaneous, discuss	11	8	3
No answer	-	-	-

"Do you feel that people here are glad to have you work for them?"

MIGRANT HEALTH ATTITUDE SURVEY
NEW JERSEY 1964

Answer	Number Persons
Total	81
Yes	75
No	0
I don't know	6
No reason for me to know	0
No reply	0

"Do they make you feel that the work you do is important?"

MIGRANT HEALTH ATTITUDE SURVEY
NEW JERSEY 1964

Answer	Number Persons
Total	81
Yes	76
No	1
I don't know	4
No reason for me to know	0

"Are you treated fairly by:"

MIGRANT HEALTH ATTITUDE SURVEY
NEW JERSEY 1964

By	Number Persons			
	Total	Yes	No	No Answer
Farmers	81	73	6	2
Crew leaders	81	52	1	28
People you work with	81	79	0	2
People in town	81	77	0	4

"Have you ever had any trouble with:"

MIGRANT HEALTH ATTITUDE SURVEY
NEW JERSEY 1964

With	Number Persons			
	Total	Yes	No	No Answer
Farmers	81	6	75	0
Crew leaders	81	6	65	10
People you work with	81	5	75	1
People in town	81	5	76	0

"DO THESE SYMPTOMS SHOW THAT YOU ARE SICK?"
MIGRANT HEALTH ATTITUDE SURVEY
NEW JERSEY 1964

SYMPTOMS	NUMBER OF PERSONS			
	Total	Yes	No	No Answer
Fever	81	37	4	40
Vomiting	81	19	10	52
Lump or Swelling	81	10	4	67
Loose Bowels	81	12	8	61
Pain	81	27	4	50
No appetite	81	41	5	35
Trouble sleeping	81	17	7	57
Dizziness	81	15	3	63
Soreness-redness with pus	81	13	4	64
Cough	81	29	2	50
Other	81	45	36	0

"WOULD YOU SEE A DOCTOR FOR ILLNESS?"
MIGRANT HEALTH ATTITUDE SURVEY
NEW JERSEY 1964

DISEASE	NUMBER OF PERSONS			
	Total	Yes	No	No Answer
Worms	80	66	14	0
Tuberculosis	80	80	0	0
Food Poisoning	80	74	4	2
Appendicitis	80	75	1	4
Syphilis	80	77	1	2
Infected Sore	80	71	6	3

"How do you know when you have Syphilis?"

Migrant Health Attitude Study
New Jersey 1964

Number of Answers	Total	1	2
Total Persons	81	80	1
Person Answers	81	79	2
Sores and Blisters	4	4	0
Rash	2	1	1
Painful Urination	1	1	0
Don't Know	62	62	0
No Answer	5	5	0
Miscellaneous	7	6	1

"How do you know when you have a serious infection?"

Migrant Health Attitude Study
New Jersey 1964

Number of Answers	Number of Persons
Total	80
When pus is present	15
When swelling is present	4
When sore is getting bigger	5
Don't Know	48
No Answer	3
Miscellaneous	5

"How do you know when you have Tuberculosis or Chest Trouble? "

Migrant Health Attitude Study
New Jersey 1964

Number of Answers	Total	1	2	3
Total Persons	80	60	17	3
Person Answers	103	60	34	9
Cough	30	13	15	2
Chest X-ray	2	2	0	0
Lose Weight	7	0	5	2
Fatigue	5	0	3	2
Spitting Up Blood	2	1	1	0
Shortness of Breath	5	1	3	1
Bad Cold	2	1	1	0
Miscellaneous	12	4	6	2
Don't Know	37	37	0	0

" How do you know when you have worms?"

Migrant Health Attitude Study
New Jersey 1964

Number of Answers	Total	1	2
Total Persons	80	68	12
Person Answers	92	68	24
Big Belly	18	11	7
Itching Anus	2	2	0
Diarrhea	3	1	2
Change of Color	8	2	6
See Them	4	4	0
Miscellaneous	25	16	9
Don't Know	27	27	0
No Answer	5	5	0

"How do you know when you have food poisoning?"

Migrant Health Attitude Study
New Jersey 1964

Number of Answers	Total	1	2	3
Total Persons	80	69	10	1
Person Answers	102	69	20	3
Vomiting	20	9	10	1
Pain in Stomach	18	2	5	1
Loose Bowels	5	0	4	1
Nausea	2	1	1	0
Miscellaneous	7	7	0	0
Don't Know	50	50	0	0

"How do you know when you have appendicitis?"

Migrant Health Attitude Study
New Jersey 1964

Number of Answers	Total	1	2
Total Persons	80	78	2
Person Answers	82	78	4
Pain in Right Side	7	6	1
Nausea	1	0	1
Pain in Various Locations in Abdomen	20	19	1
Miscellaneous	2	1	1
Don't Know	52	52	0

"DO YOU SEEK HELP FROM PERSONS OTHER THAN A DOCTOR WHEN YOU ARE ILL?"
MIGRANT HEALTH ATTITUDE STUDY
NEW JERSEY 1964

Number of Answers	Total	1	2
Number of Persons	81	75	6
Person Answers	87	75	12
Mother	8	5	3
Nurse	4	4	0
Other Members of Family	6	4	2
Church Elder	2	2	0
Friends	4	2	2
Drugman	7	6	1
Witch Doctor	6	4	2
Miscellaneous	8	6	2
No One	42	42	0

"WHAT DO YOU DO WHEN YOU OR A MEMBER OF YOUR FAMILY IS ILL?"
MIGRANT HEALTH ATTITUDE STUDY
NEW JERSEY 1964

	Total	Number of Persons		
		Yes	No	No Answer
Go to a Doctor	81	76	5	0
Go to Another Person	81	7	6	68
Home Remedies	81	23	18	40
Other	0	0	0	0
Miscellaneous	81	7	0	74

"WHAT FOODS ARE NEEDED FOR GOOD HEALTH?"
MIGRANT HEALTH ATTITUDE SURVEY
NEW JERSEY 1964

Number of Answers		Frequency of Answer 1	2	3	4	5
Number of Persons	70	15	18	28	7	2
Person Answers	173	15	36	84	28	10
Milk	42	0	10	23	7	2
Meat	34	2	11	14	5	2
Eggs	25	0	4	14	5	2
Vegetables	20	1	4	10	3	2
Fruits	6	1	0	4	1	0
Miscellaneous disc.	46	11	7	19	7	2

"WHAT SHOULD PEOPLE DO TO STAY WELL?"
MIGRANT HEALTH ATTITUDE SURVEY
NEW JERSEY 1964

Number of Answers	Total	1	2	3	4	5
Number Persons	81	39	14	13	11	4
Person Answers	170	39	28	39	44	20
Sleep	33	5	7	6	11	4
Washing hands	23	1	0	8	10	4
Wear Shoes	22	0	2	6	10	4
Food and Eating Habits	21	9	5	5	1	1
Related to cleanliness	20	10	3	3	2	2
Shots or Injections	17	1	1	4	7	4
See physician for check-ups	10	2	4	4	0	0
Protection from cold & weather	3	0	0	0	2	1
Miscellaneous	21	11	6	3	1	0

"WHAT THINGS DO YOU THINK BRING FLIES AND RATS INTO OUR HOUSES?"
MIGRANT HEALTH ATTITUDE SURVEY
NEW JERSEY 1964

Number of Answers	Total	1	2	3	4
Number of Persons	81	56	13	10	2
Person Answers	120	56	26	30	8
Garbage	23	9	5	7	2
Food not stored right	14	2	3	8	1
Unclean stuff	34	19	10	4	1
Trash junk	22	13	7	1	1
Screens - use and condition of	11	1	1	8	1
Toilets - condition - placement of	2	1	0	0	1
Miscellaneous	14	11	0	2	1

"Name shots which will protect you from sickness."

MIGRANT HEALTH ATTITUDE STUDY
NEW JERSEY 1964

NUMBER OF ANSWERS	TOTAL	1	2	3	4
Number of Persons	81	57	17	5	2
Person Answers	114	57	34	15	8
Polio	37	18	13	4	2
TB	14	3	6	4	1
Tetanus	5		1	2	2
Diphtheria	5		3	1	1
Whooping Cough	2			2	
Smallpox	3	1		1	1
Don't know	30	29	1		
Misc.	18	6	10	1	1

"When and why did you see a Doctor?"

MIGRANT HEALTH ATTITUDE SURVEY
NEW JERSEY 1964

Time in Years		Under 1 Year	1 yr. up to 3 yrs	3 yrs. up to 10 yrs.	Over 10 yrs.	No Answer
Number of Persons	69	47	10	5	3	4
Number of Answers	72	47	10	6	4	5
Cold	10	6		1	1	2
Injuries	12	8	3	1		
X-rays	5	5				
Surgery	6	4	1	1		
Miscellaneous	39	24	6	3	3	3
Never	12	0				

MIGRANT WORKER COMPENSATION ACCIDENTS, GLASSBORO SERVICE ASSOCIATION, BY TYPE AND MONTH

ACCIDENT PREVENTION PROGRAM

NEW JERSEY 1964

TYPE OF ACCIDENT	TOTAL	APRIL	MAY	JUNE	JULY	AUG.	SEPT.
TOTAL ACCIDENTS	189	7	39	39	35	45	24
Sprains or strains from lifting or carrying	18	1	2	4	2	6	3
Sprains or strains from losing balance while lifting or carrying	13	0	1	3	4	4	1
Sprains or strains from pulling, picking and other causes	12	0	3	4	2	2	1
TOTAL SPRAINS AND STRAINS	43	1	6	11	8	12	5
Fall or loss of balance-same level	17	1	6	3	2	4	1
Fall or loss of balance-on or off ladder	14	0	0	1	3	6	4
Trip over object	12	0	3	3	2	0	4
Fall or loss of balance-other	11	0	1	3	3	3	1
TOTAL FALLS OR LOSS OF BALANCE	54	1	10	10	10	13	10
Knives and tolls	23	3	11	6	1	2	0
Equipment and machinery	26	0	6	3	8	7	2
TOTAL KNIVES, TOOLS, ETC.	49	3	17	9	9	9	2
Foreign body entering eye	19	2	4	1	4	5	3
Other accidents	24	0	2	8	4	6	4
Non-accidental skin conditions	18	0	1	4	8	5	0